

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12480

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 70 Film 6405 10/2/68
CERTIFICATE OF DEATH

12490

1. DECEASED-NAME (Type or print) <i>Petronella M. Adams (Adomaitis)</i>			2a. DATE OF DEATH 9 Month 22 Day 68 Year			2b. HOUR 4 A M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 15 1885</i>		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Lithuania</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>35 Dunganrie Rd</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>35 Dunganrie Rd</i>							
14. FATHER'S NAME First <i>John</i> Middle <i>Kithis</i> Last <i>Kithis</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Tavros</i> Last <i>Tavros</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>213 48 5410</i>		17. INFORMANT Address <i>Mr. John P Adams 35 Dunganrie Rd Balto 28 Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Cervix metastasizing to brain</i> <i>180X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>171X</i>							
19a. DATE OF OPERATION <i>July 1963</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Cervix</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 63		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-2</i> , 19 <i>63</i> , to <i>9/22</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John P. Vetrock Jr MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9/23/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN P. VETROCK JR</i>		22e. ADDRESS <i>1227 Washington Blvd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-25-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md Balto Md</i>	
24. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc 1600 Hollins St. Balto Md</i>				25a. REC'D BY REGISTRAR <i>SEP 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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12481

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12491

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Grace Fowble Akehurst						9 24 1968			1:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		3-9-1893			75 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md.		USA					Balto. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hereford, Md.			York Rd., Hereford, Md.			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSURE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.			Hereford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		York Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Peter Kemp Fowble			Irene Florence Cole								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			218-32-2889			Mrs. Jane A. Pearce, Butler, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA of Rectum</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>154x</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>Sept. 24</u> , 19 <u>68</u> , that (I) (we) saw the deceased alive on <u>Aug.</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph H. Hooper, Jr. M.D.</u>						22c. DATE SIGNED 9-24-1968					
22d. PHYSICIAN'S NAME (Type) Joseph H. Hooper, Jr. M.D.						22e. ADDRESS 108 E. 33rd St. Balto., Md. 21218					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9-26-1968		Black Rock Cem.		Balto. County, Md.					
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE SEP 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12482

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12492

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ALBERT			First Middle Last ALBERS			2a. DATE OF DEATH Month 9 Day 3 Year 68			2b. HOUR 9:15AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7/20/07			6. AGE (In years last birthday) 61 YRS.		
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md.		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLAY MAKER			12b. KIND OF BUSINESS OR INDUSTRY INSULATOR CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ---			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3225 E. Baltimore Street			14. FATHER'S NAME First JOHN Middle M. Last ALBERS			15. MOTHER'S MAIDEN NAME First MARY Middle GRAU Last ---					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO. 215 09 63 21			17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE URINARY BLADDER (TERMINAL) 188X DUE TO, OR AS A CONSEQUENCE OF (b) WITH METASTASIS TO INGUINAL LYMPH NODE AND LUMBAR DUE TO, OR AS A CONSEQUENCE OF (c) VERTEBRAE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1810											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 6/9/68 , 19__, to 9/3/68 , 19__, that (X) (we) last saw the deceased alive on 9/3/68 , 19__, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Erhard J. Bunyor M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/3/68		
22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR, M. D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9-6-68			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DABROWSKI FUNERAL HOME			25b. REGISTRAR'S SIGNATURE SEP 6 1968 Charles Judge		

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1. 1900-1901

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BOOK FOR THE YEAR 1912

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23c, telephone call, Hubbard F. H. 9/23/68 cao

12493

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
Jesse		A.		Albright				Sept.		21		1968		8:00		A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		9-27-87		80		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Baltimore, Md.		U.S.A.				Baltimore											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Catonsville		Spring Grove State Hosp.															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Maryland		Baltimore		Bloomfield Park, Md.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1723 Wilson Avenue									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Jesse		P.		Albright				Anna		Orndorf							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
Yes, no, or unknown		214-54-7912-1		Spring Grove State Hosp. Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>																	
4409 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) <u>Generalized Arterioscleriosis Intestinal fibrosis</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Of both lungs																	
(c) <u>Ca. of rectum and poss. metastasis</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
4500																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 9-8-68 to 9-21-68, that (I) (we) last saw the deceased alive on 9-21-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Evelio A. Felipe</u>																22c. DATE SIGNED	
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																9-21-68	
22d. PHYSICIAN'S NAME (Type) <u>Evelio A. Felipe</u>																22e. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
BURIAL		9-24-1968		Meadow Ridge ME, Oliver Cemetery				Baltimore, Maryland									
24. FUNERAL DIRECTOR ADDRESS																	
Howard H. Hubbard, 4107 Wilkens Ave. 21229																	
25a. REC'D BY REGISTRAR																	
25b. REGISTRAR'S SIGNATURE																	
SEP 24 1968																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12484

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12494

1. DECEASED-NAME (Type or print) LESLIE CLINTON ALMONY			2a. DATE OF DEATH Month SEPTEMBER Day 5 Year 1968			2b. HOUR 8:45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 31, 1899		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH White Hall		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hunter Mill Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Duncan		15. MOTHER'S MAIDEN NAME Sally Davis		16. SOCIAL SECURITY NO. 213-28-6644			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		17b. INFORMANT Mrs. Rose E. Almony		17c. ADDRESS Hunter Mill Road White Hall, Md. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X G.I. C. V. disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1967 , to 9/5, 1968 , that (I) (we) lost the deceased alive on 9/1, 1968 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. M. France				22c. DATE SIGNED 9/6/68		22d. ADDRESS PARKTON, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/8/1968		23c. NAME OF CEMETERY OR CREMATORY Weisburg		23d. LOCATION (City or Town) (County) (State) White Hall, Balto. Md.	
24. FUNERAL DIRECTOR Charles E. Kurtz				25a. REC'D BY REGISTRAR Jarrettsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000

Carson City

A. C. & Co.

A. M. France
A. M. France

755 KNOX RD

4/11/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12485										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12495									
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR									
First Middle Last RAYMOND TITUS AMSPACHER										Month 9 Day 5 Year 68										12:30 PM									
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			White			Oct. 19, 1918			49 YRS			MONTHS			DAYS														
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Penna			U.S.A						BALTIMORE Md																				
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY														
BALTIMORE, MD					GREATER BAL. MED. CEN					Mechanic					Auto														
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS?					13e STREET AND NUMBER									
Pa.					York					Glen Rock					YES <input type="checkbox"/> NO <input type="checkbox"/>					R.D. #1									
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Robert					Amspacher					Amanda Lucabaugh																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b SOCIAL SECURITY NO					17 INFORMANT Address																			
yes					World #2					193-18-6479 Edith Krebs Amspacher R.D. #1 Glen Rock, Pa																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA & TRACHEOBRONCHITIS																													
144X DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) WIDESPREAD CLEFT OF MOUTH																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
170X																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.					21f. LOCATION Street or R.F.D. No. City or Town County State																			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																													
22a I certify that (I) (this hospital) attended the deceased from 8/16, 1968, to 9/5, 1968, that (I) (we) last saw the deceased alive on 9/5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED									
M. Estelle Connolly M.D.																				9/5/68									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
M. ESTELLE CONNOLLY, MD.										6701 N CHARLES ST, BALT, MD																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c. NAME OF CEMETERY OR CREMATORY					23d LOCATION (City or Town) (County) (State)														
Burial					9/7/68					Susquehanna Memorial					York #3 York Pa?														
24. FUNERAL DIRECTOR										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE									
H. K. Knappe										Glen Rock, Pa										DATE SEP 9 1968 J. Charles Judge									



12486

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

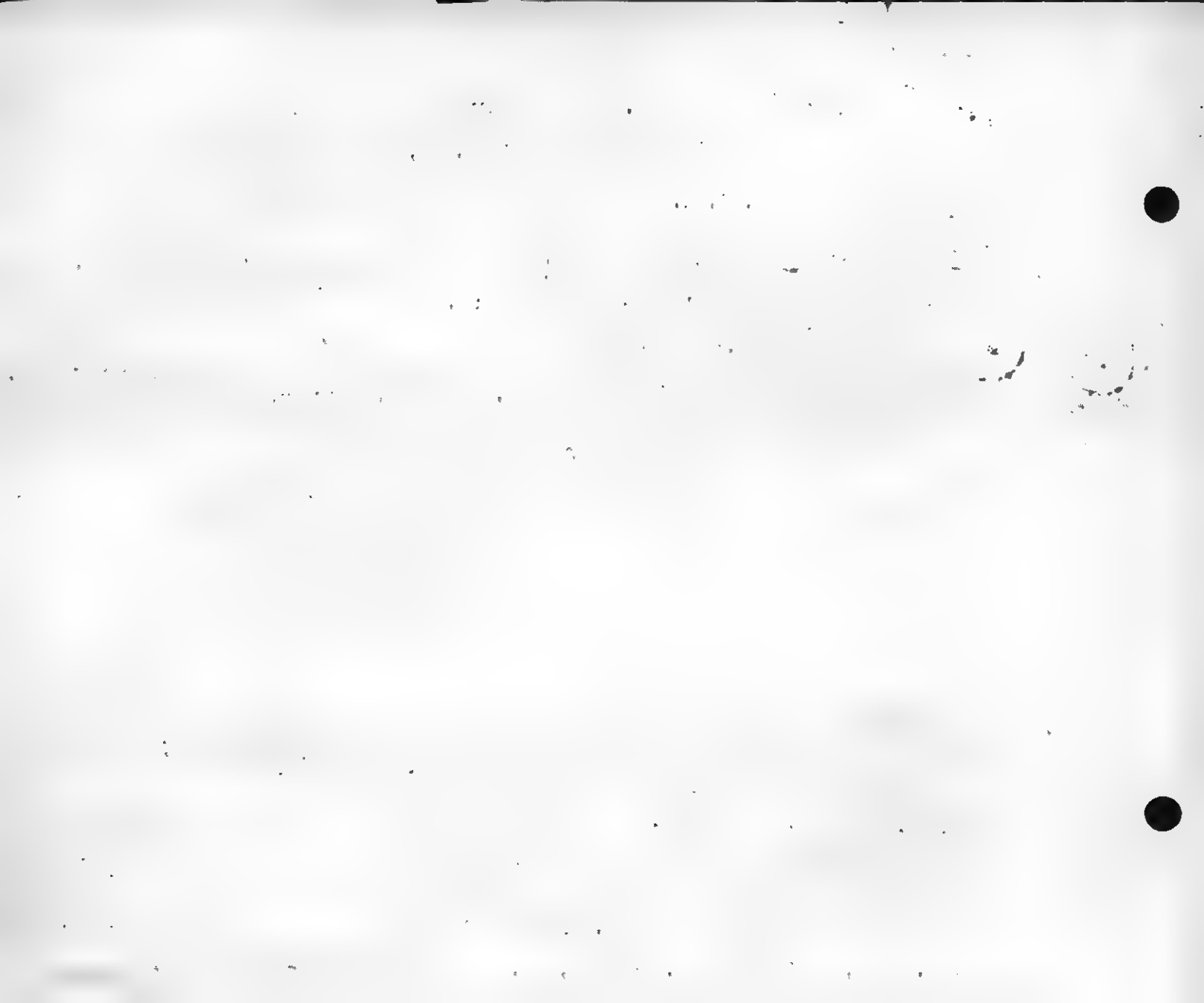
CERTIFICATE OF DEATH

12496

1 DECEASED NAME (Type or print) Elmer F. Andrews			2a DATE OF DEATH Month September Day 20 Year 1968			2b HOUR 7⁰⁰ A M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 21, 1897		6 AGE (In years last birthday) 70 YRS.	
7a BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Sparrows Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1010 "H" Street		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired- Bethlehem Steel Co.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Sparrows Pt.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 1010 "H" Street		14 FATHER'S NAME First John Middle W. Last Andrews		15 MOTHER'S MAIDEN NAME First Agnes Middle Olmstead Last Olmstead			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? Yes (If yes give year or dates of service) WWI		16b SOCIAL SECURITY NO 213-07-7998		17 INFORMANT (Wife) Mrs. Gladys D. Andrews, 1010 "H" Street		Address Sparrows Pt. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CORONARY ART. DUE TO, OR AS A CONSEQUENCE OF (c) D.I.S. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. over 30 yrs.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21c LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 20, 1968 , to Sept 20, 1968 , that (I) (we) saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Louis D. Olsen MD				22c DATE SIGNED 9/20/68		22d PHYSICIAN'S NAME (Type) LOUIS D. OLSEN, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 9/24/68		23c NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div>1</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>12197</div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>								d. STREET ADDRESS <u>707 Washington Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Angela</u> Last <u>Anthony</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1968</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26, 1897</u>		9. AGE (in years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Rigley</u>						14. MOTHER'S MAIDEN NAME <u>Clara Catherine Mullen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>None</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 20, 1959</u> to <u>SEPT 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPT 28, 1968</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>T. C. Siwinski</u>								22b. DATE SIGNED <u>10/2/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>								22d. ADDRESS <u>206 W. PENNA. AVE. TOWSON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>OCT. 3, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>John Burman Sons, Towson, Md.</u>						25a. REC'D BY REGISTRAR <u>DATE OCT 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

3

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12483

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12198

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
JOSEPH				AUSBY	Month 9 Day 18 Year 1968		4:45P M		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
MALE	NEGRO		8/10/06		82 YRS				
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
VIRGINIA		U.S.A.				BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VET. ADM. HOSPITAL		LABORER		CONSTRUCTION			
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND				BALTIMORE				911 N. CAROLINE STREET	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
DULCON				AUSBY	FRANCES				FAULCON
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes, give war and dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address			
YES		WW II		217 07 66 02		CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.								HOURS	
IMMEDIATE CAUSE (a) HEPATIC COMA									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								UNKNOWN	
(b) HEPATOMA WITH METASTASIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c) LAENNET'S CIRRHOSIS								YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
281									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No				
22a. I certify that (X) (this hospital) attended the deceased from 9/9/68, 19__, to 9/18/68, 19__, that (X) (we) last saw the deceased alive on 9/18/68, 19__, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
Peter Juwan							9/20/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
PETER V. JUVAN, M. D.		VAH FORT HOWARD, MARYLAND							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		9-23-68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND			
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Wilson Funeral Home		DATE SEP 26 1968		Charles Judge					
25c ADDRESS		25d DATE		25e ADDRESS					
25c ADDRESS		25d DATE		25e ADDRESS					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Thomas A. Barnes						Month Day Year		4 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		2d HOUR	
M	W.	JULY 28-1905	63 YRS			Month Day Year		4 P M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MD.		U.S.A.				Baltimore County		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Randallstown Md.			Balto. Co. General Hosp.			Janitor		Md. Cup	
3a USUAL RESIDENCE (Where deceased lived, if institutional admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Baltimore			Reisterstown		P.O. Box 379 Owings Mills Md.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A DEN NAME First Middle Last						
William Barnes			Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
No			216-03-5414			Mrs. Mary E. Barnes Box 379 Owings Mills			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio Vasc Dis.</u>								5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				HOUR A.M. P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
J. Nelson McKay		J. Nelson McKay, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		9-20-68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION REMAINS (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Sept. 21, 68		New Cathedral Cem.		Baltimore Maryland Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Loring Byers 8728 Liberty Rd. Randallstown Md.				SEP 23 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12490

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12500

1. DECEASED-NAME (Type or print) CHRISTIAN			First Middle Last			2a. DATE OF DEATH Month Day Year SEPTEMBER 23, 1968			2b. HOUR 3:00 AM		
3 SEX MALE			4 RACE CAUCASIAN			5 DATE OF BIRTH JAN 3, 1890			6 AGE (In years last birthday) 78 YRS		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHANIC - ELECTRICIAN			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 2910 SALISBURY AVENUE			14. FATHER'S NAME First Middle Last CLEMENTS R BAUER			15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE ZWICK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO. WW I 217 54 2906			17. INFORMANT Address CLINICAL RECORDS, VAH FT HOWARD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4207 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) OLD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS WITH PYOURETER, BILATERAL, OLD											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/2/68 , 19__, to 9/23/68 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/23/68 , 19__, and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (d.d.) view the body after death.											
22b. SIGNATURE J. D. Talbert, M.D. DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 9 23 68		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9/26/68			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR Joseph P. Zannino			ADDRESS ZANNINO FUNERAL HOME			25a. REC'D BY REGISTRAR OCT 4 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		
30M REV 1/68			DATE BALTIMORE, MD.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) ROYAL THEODORE BAUER SR.					2a. DATE OF DEATH Month 9 Day 6 Year 68		2b. HOUR P Min 25		
3. SEX MALE		4. RACE MALE CAU.		5. DATE OF BIRTH 10-22-97		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Balto. Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Balto.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Landscape Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5100 Hazelwood Avenue	
14. FATHER'S NAME First Middle Last Frank Bauer				15. MOTHER'S MAIDEN NAME First Middle Last Annie Roase					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 2-18-09-3389		17. INFORMANT Address Mrs. Marie Bauer 5100 Hamilton Avenue 6					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA OF LUNG WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 165x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9-1- , 19 68 , to 9-6 , 19 68 , that (I) (we) last saw the deceased alive on 9-6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mohammad M.D.				22c. DATE SIGNED 9-6-68		22d. PHYSICIAN'S NAME (Type) D. MOHAMMED, M.D.			
22e. ADDRESS 6701 N CHARLES ST BALT, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-9-1968		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				25a. REC'D BY REGISTRAR DATE SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

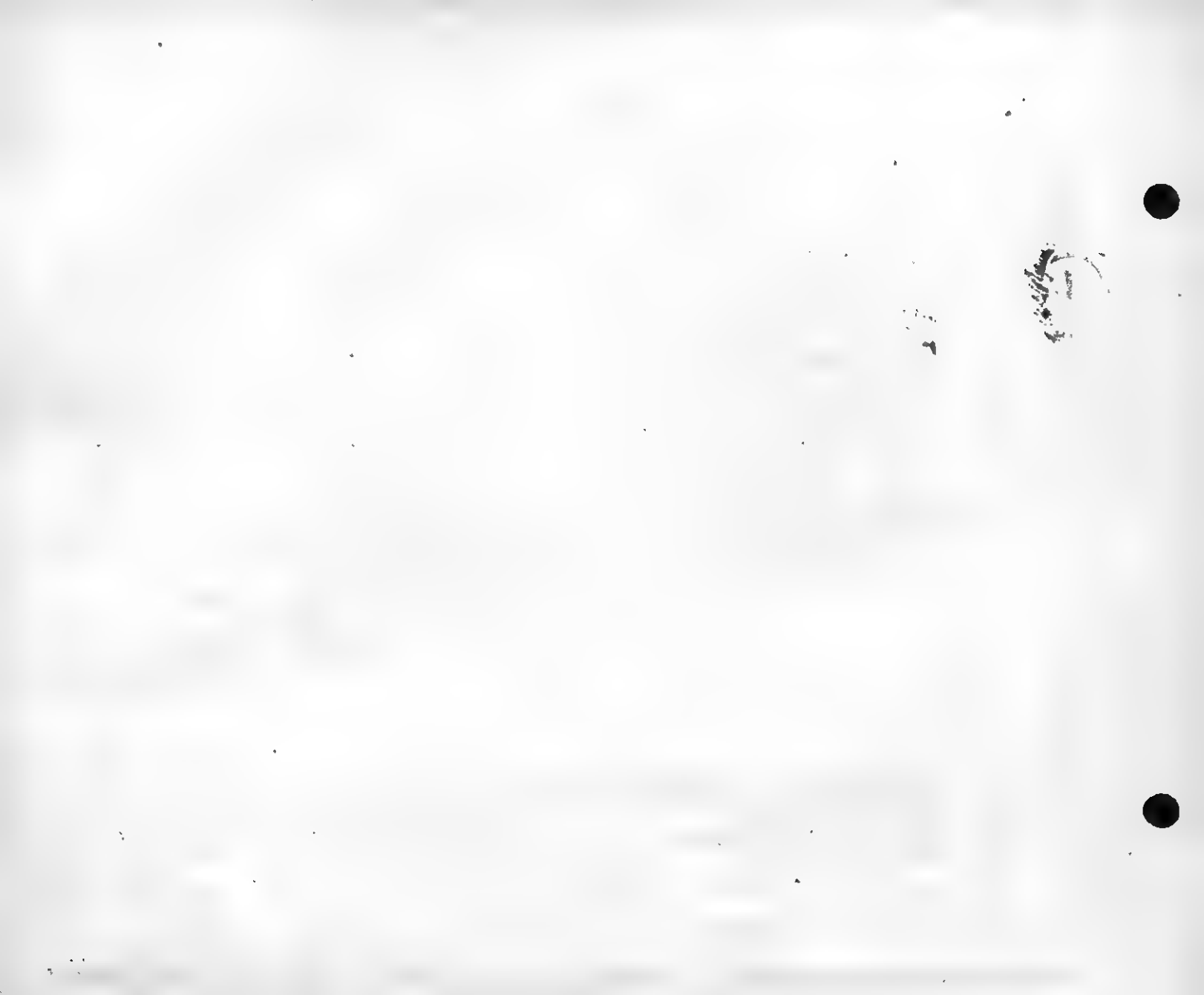
12492

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 11 Film 3405 12492

CERTIFICATE OF DEATH

12502

1 DECEASED NAME (Type or print) First Middle Last Theresa Beitz			2a DATE OF DEATH Sept Month 17/68 Year		2b HOUR M
3. SEX Female	4. RACE white	5 DATE OF BIRTH Sept 23 1878		6 AGE (In years lost birthday) 89 YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Colgate Balto Co		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8000 Landsdale Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore Co	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER 8000 Landsdale	
14 FATHER'S NAME First Middle Last John H Burk			15 MOTHER'S MAIDEN NAME First Middle Last Josephine Grimm		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT Miss Minnie Kuehne 5813 Glenkirk Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 67</u> to <u>March 19 68</u> , that (I) (we) last saw the deceased alive on <u>March 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Joseph J. Cameron M.D.</u>		DEGREE M.D.		22c DATE SIGNED 9/18/68	
22d. PHYSICIAN'S NAME (Type) JOSEPH J. CAMERON		22e ADDRESS 1012 Old West Pt Rd # 24			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE Sept 20/68	23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore County	
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road		ADDRESS		25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12493

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
VICTOR		STEPHEN	X	BENNETT	SEPT 20 1968			5:10 PM	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
MALE	WHITE		NOV. 8, 1887		8x 80 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		2b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH'S HOSPITAL		RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>		611 PARK AVE.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Louis				Bennett	Maria				Hophahn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown		(If yes give year and date of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes		WW		212-16-9046		Mr J Lloyd Wilkinson		200 Title Bldg	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal carcinomatosis</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>carcinoma of pancreas</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF _____									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1211									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from <u>SEPT 7</u> , 19 <u>68</u> , to <u>SEPT 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>SEPT 20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)								Sept. 21, 1968	
R. Orjuela-Gomez, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/24/68		Rox Loudon Park		Baltimore, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland				SEP 24 1968		J Charles Judge			



FOR STATE
HEALTH DEPT.

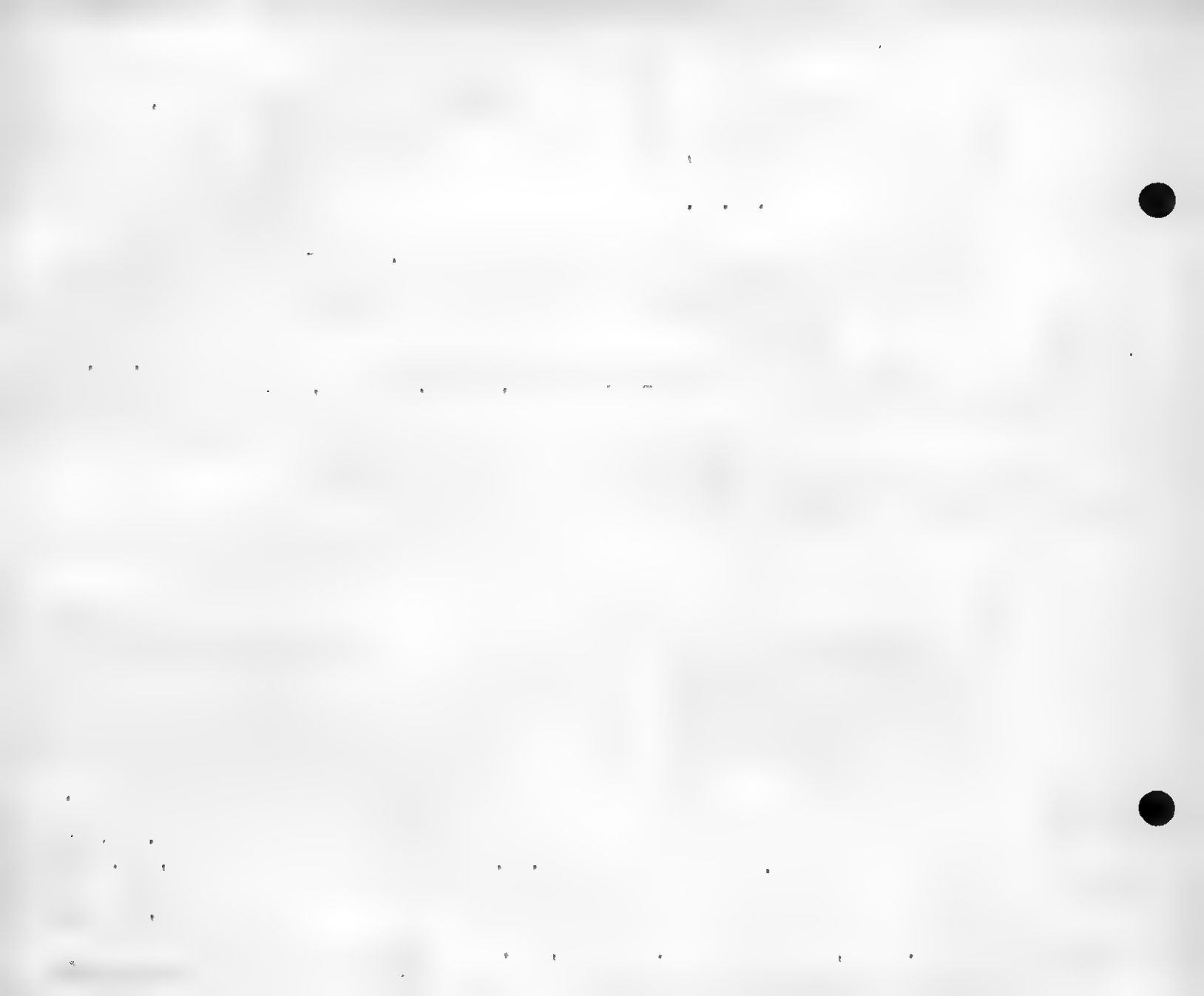
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12494

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12504

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED		Month		Day		Year		2b HOUR	
Maria						Binetti		Sept. 16, 1968								5:41 M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER YEAR MONTHS		YEAR DAYS		IF UNDER 24 HRS HOURS		MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	July 31, 1894		74 YRS										Sept. 16		1:25 M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH										Md	
Italy		U. S. A.				Baltimore											
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Edgemere		RFD Box 40 Millers Island Rd.		Self-employed		Seafood											
13a USJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER									
Maryland		Baltimore		Edgemere				RFD Box 40 Millers Island Rd									
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
Not Known								Not Known									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT (Son)		ADDRESS											
No		092-01-7540		Mr. Ray A. Binetti, Rt. #10 Box 83B		Balto. Md. 21219											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4127		Sub-ARACHNOID ITHEM-ROPPED		A-S-C I-LEASHI				8 hrs									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)													
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6800 Mornington Rd.		22b DATE SIGNED		Sept. 17, 1968							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M. D.		ADDRESS (Street, city, town, or county)											
Melvin B. Davis						Dundalk, Md. 21222											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)							
Burial		9/19/68		Oak Lawn Cemetery		Baltimore, Maryland											
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
John J. Duda, 7922 Wise Ave. Dundalk, Md.						SEP 19 1968		J. Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
<div>12495</div> <div>CERTIFICATE OF DEATH</div>												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR p. m.			
Margaret			S. Birch			Sept. 2, 1968			5:20 p. m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female		white		March 4, 1902			66 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md.		U. S.					Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville			SPRING GROVE STATE HOSP.			housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Md.		Pr. Geo.		Beltsville				13011 Elkridge Street				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
PHILIP HAYDEN			UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address						
NO			NONE			Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter on y one cause per ne for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction (thrombosis) DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1968, to Sept. 2, 1968, that (I) (we) last saw the deceased alive on Sept. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b. SIGNATURE				DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Ramon A. Boza										9-3-68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
				SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
BURIAL		9-5-1968		ARLINGTON NATL. CEM.				ARLINGTON, VIRGINIA				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
W.W. CHAMBERS Co. RIVERDALE, MD.				DATE SEP 10 1968				J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-68

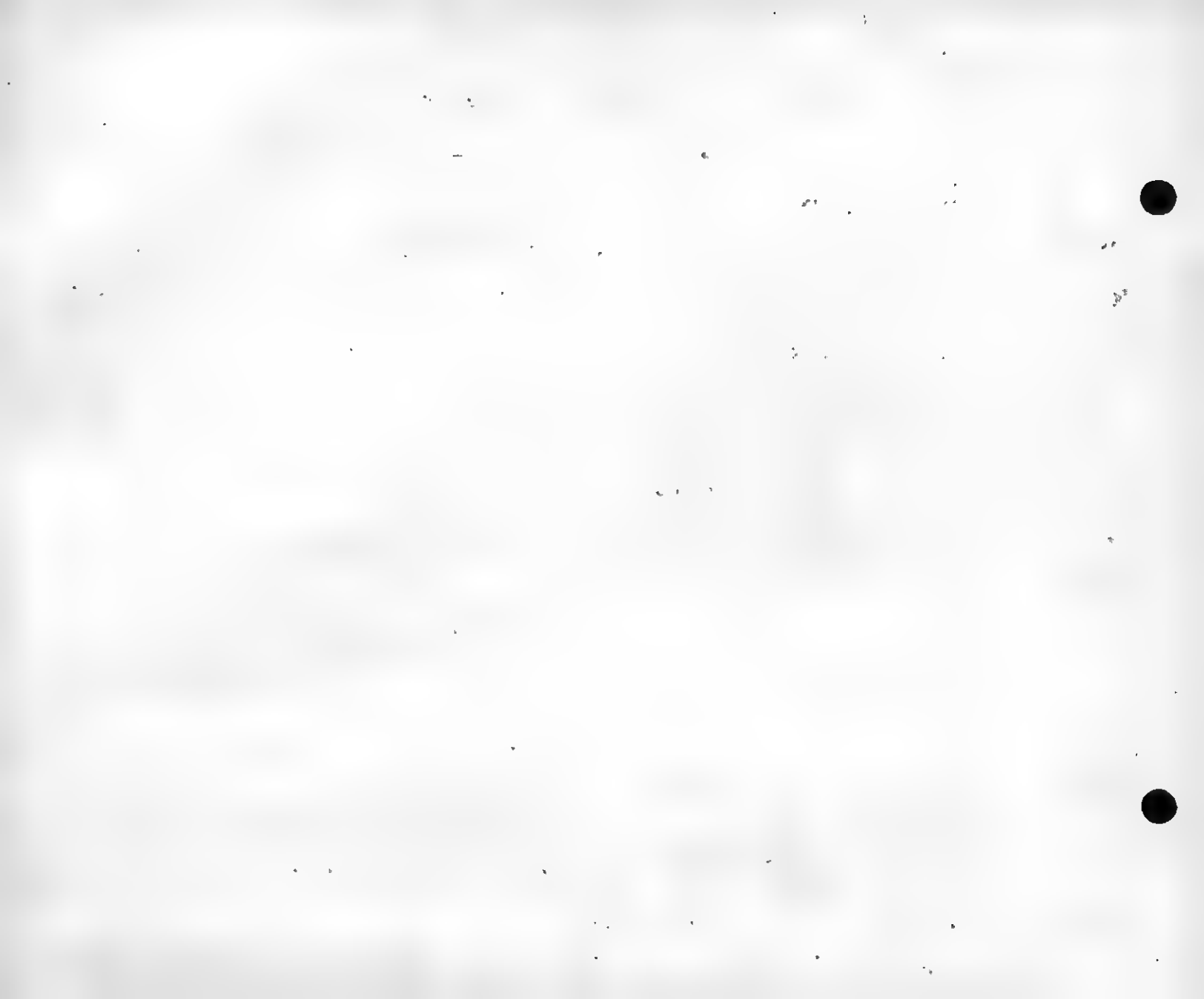
12496

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12506

CERTIFICATE OF DEATH

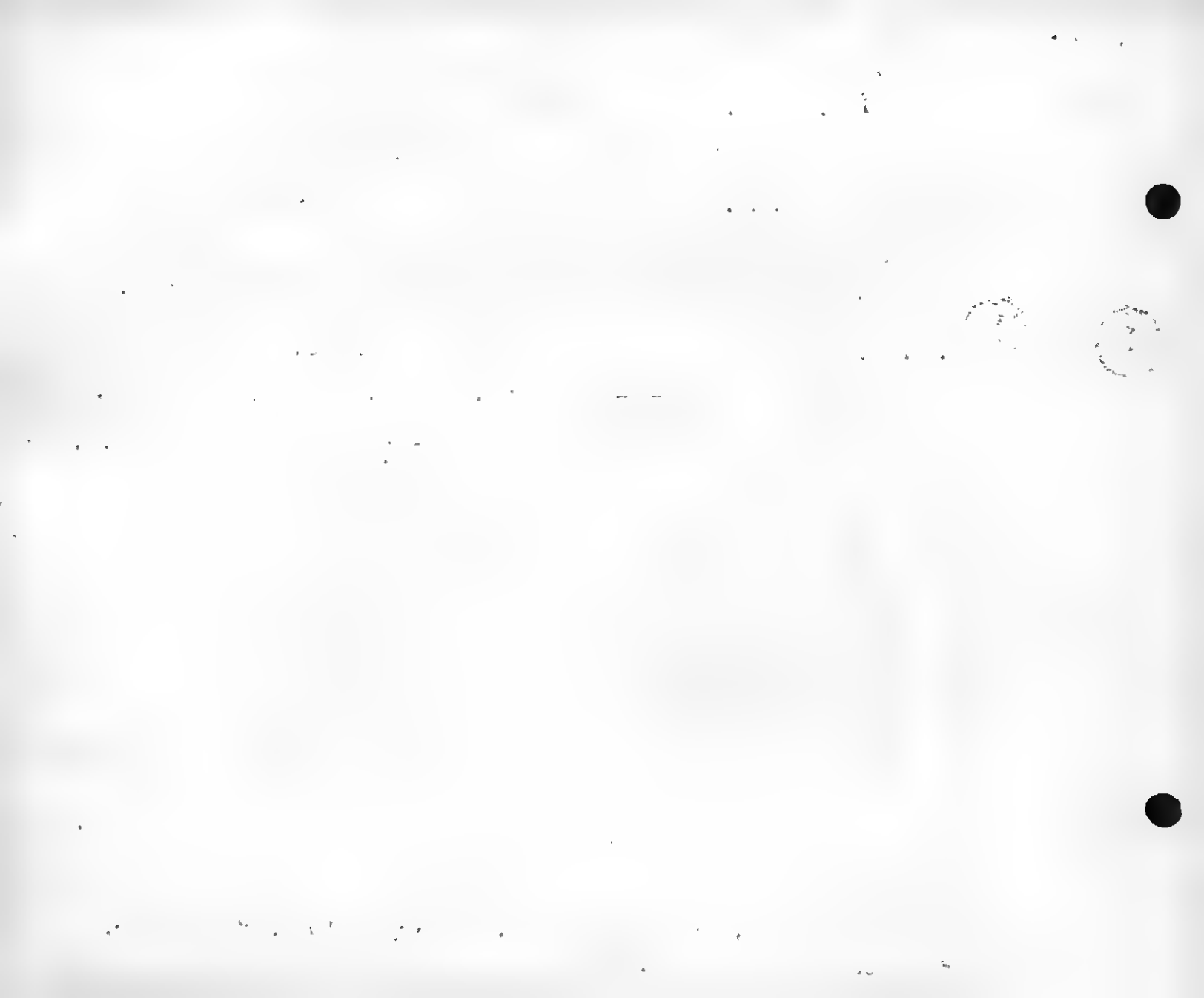
1. DECEASED-NAME (Type or print)		First William	Middle Francis	Last Birkmaier	2a. DATE OF DEATH 9 Month 16 Day 1968 Year		2b. HOUR 12:45 PM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH 9-6-1888		6 AGE (In years last birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY retired			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		13b. COUNTY Woodbine		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. #1 Woodbine, Md. 21797			
14 FATHER'S NAME First Middle Last Julius Birkmaier		15 MOTHER'S MAIDEN NAME First Middle Last unknown Josephine Karhoff							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 216-01-4281		17 INFORMANT family					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>162.1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of lung, right lower lobe.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>September 10 1968</u> , to <u>September 16 1968</u> , that (X) (we) last saw the deceased alive on <u>September 16 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Christina Feliciano, M.D.</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/16/68			
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-19-1968		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Chas. F. Evans & Son 8802 Hanford Rd				25a. REC'D BY REGISTRAR SEP 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12497												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Ernest E. Blandin						2a. DATE OF DEATH Sept Month 16 Day 68 Year			2b. HOUR 8:35 AM			
3 SEX M		4. RACE White		5. DATE OF BIRTH June 21, 1919			6. AGE (In years last birthday) 49 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Augusta Kan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Harrison Ville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 713 011 Howard Rd. 21208			
14. FATHER'S NAME First Middle Last O. A. Blandin						15. MOTHER'S MAIDEN NAME First Middle Last Florence Ferguson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. WWII 512-07-0642			17. INFORMANT Address Mrs. Helen P. Blandin 713 Howard Rd. 21208						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 162.8												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Dec 1967 , to Sept 16, 1968 , that (I) (we) last saw the deceased alive on Sept 16, 1968 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE David I. Miller DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 9-16-68						
22d. PHYSICIAN'S NAME (Type) David I. Miller		22e. ADDRESS 9115 Reisterstown Rd.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept, 18, 68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. City Md.						
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. 21133						25a. REC'D BY REGISTRAR DATE SEP 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				



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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) BRIEN, CARRIE		2a. DATE OF DEATH Month SEPT Day 29 Year 1968		2b. HOUR 11:35 PM
3. SEX FEMALE	4. RACE CAU	5. DATE OF BIRTH NOV. 9 1888	6. AGE (In years last birthday) 79 YRS	7. UNDER 1 YEAR MONTHS 11 DAYS 15
7a. BIRTHPLACE (State or foreign country) Penna	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF POSTERIOR INSTITUTION (if not in hospital give street address) CHESAPEAKE MANOR HOME	12a. USUA. OCCUPATION (Kind of work done during most of work ng life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 327 MARGARET AVE.
14. FATHER'S NAME First Robert Middle CHARLES Last BILGER	15. MOTHER'S MAIDEN NAME First SYLVIA Middle BOCDAR Last BOCDAR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT BREAST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL & GEN. LESIONS DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL THROMBOSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MOS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 68 , to 9/29 , 19 68 , that (I) (we) last saw the deceased alive on 9/28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Isaac W. Mintzer	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/29/68 and		
22d. PHYSICIAN'S NAME (Type) ISAAC W. MINTZER	22e. ADDRESS 3009 EVERGREEN AVE BALTO			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-3-1968	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City or Town) (County) (State) Shanokin Baltimore Md	
24. FUNERAL DIRECTOR Long Byers	ADDRESS 8728 Liberty Road	25a. RECD BY REGISTRAR OCT 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12499

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12509

1. DECEASED-NAME (Type or Print) ARSELLA ALICE BROOKS			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year 19 <input checked="" type="checkbox"/> 19			2b. HOUR M
3 SEX Female	4 RACE Negro	5. DATE OF BIRTH May 29, 1924	6 AGE (In years last birthday) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 9 Day 21 Year 1968
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1014 Hollins St.
14 FATHER'S NAME First Middle Last John Gilbert			15 MOTHER'S MAIDEN NAME First Middle Last Mary Monroe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT ADDRESS Mary Washington 1014 Hollins St.		
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION 7-21-68		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town or county)		22b. DATE SIGNED 9-21-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/21/68		23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR <i>William J. ...</i>		ADDRESS <i>3115 ...</i>		25a. REC'D BY REG. STRAR DATE SEP 25 1968		25b. REG. STRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12500		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12510	
1 DECEASED NAME (Type or print)		First		Middle		Last	
Susie		Matilda		BROSEKER			
2a DATE OF DEATH		Month		Day		Year	
September		19		1968		8:15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Female		White		November 15, 1883		84 YRS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore, Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		ST. JOSEPH HOSPITAL		Homemaker			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY L.I.M. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Baltimore		Baltimore,		3503 Parkside Dr.	
14. FATHER'S NAME		First		Middle		Last	
Theodore McNeir							
15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Annie Shue							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		21213	
		220-46-6981T		Walter Broseker, son,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary carcinomatosis sec. to carcinoma of</u>							
1538 DUE TO, OR AS A CONSEQUENCE OF <u>large bowel</u>							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27/</u> , 19 <u>68</u> , to <u>9/19/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/19/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jaime Punzalan</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>9/19/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Jaime Punzalan, M.D.</u>				22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Entombment		9/23/68		Lorraine Mausoleum		Baltimore, Md.	
24 FUNERAL DIRECTOR ADDRESS <u>Schiunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

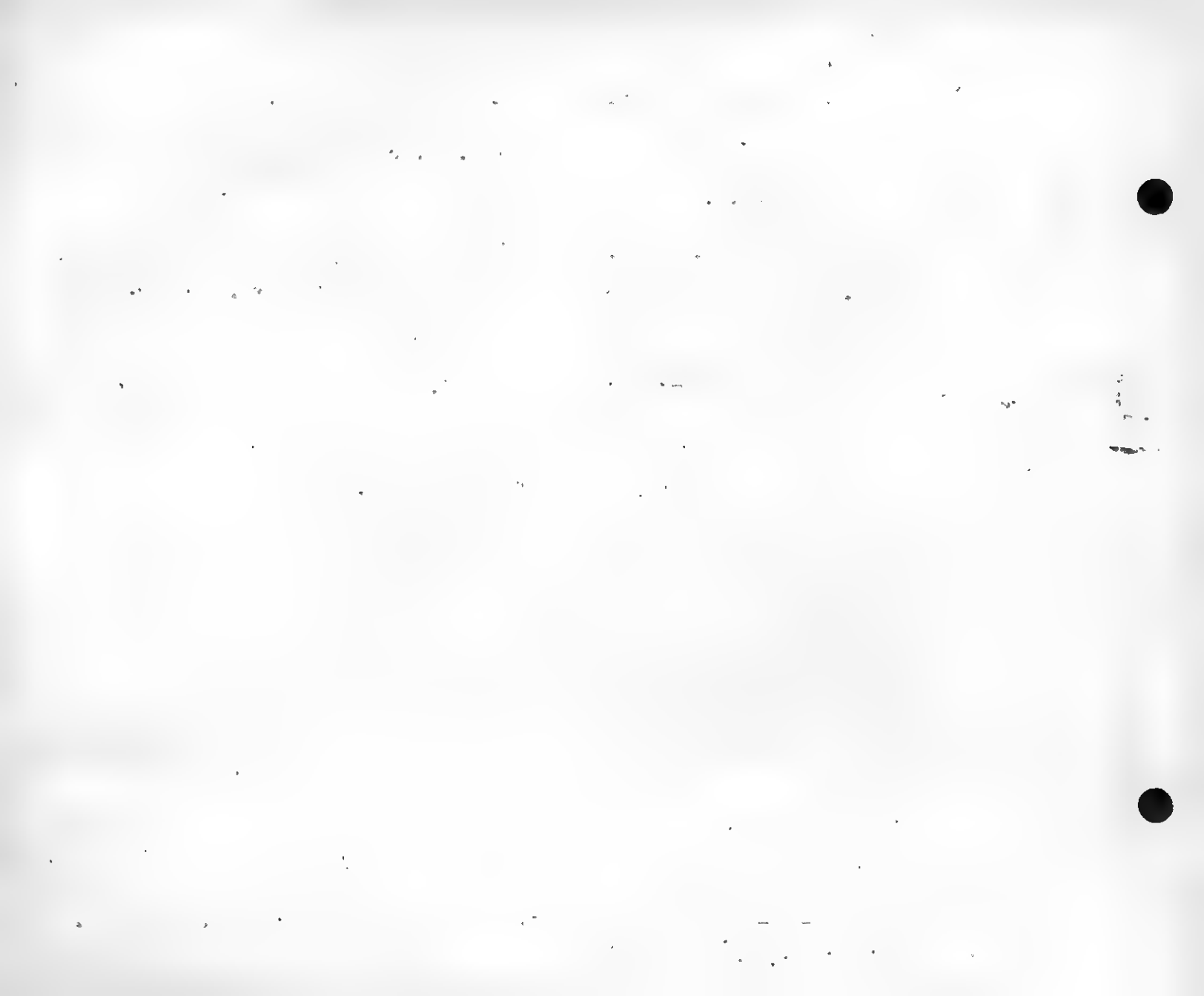
12501

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12511

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) KATHERINE E. BRUCKSCH			2a. DATE OF DEATH 9 Month 26 Day 68 Year			2b. HOUR 1:40 P			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH Dec. 20. 1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House-wife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 105 St. Elmo Court	
14. FATHER'S NAME First Middle Last Conrad Hoehre			15. MOTHER'S MAIDEN NAME First Middle Last Barbara ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 219-20-6010A		17. INFORMANT Address Elta B. Dixon 105 St. Elmo Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH HEART BLOCK 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4d01 DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 68 , to 9/26 , 19 68 , that (I) (we) last saw the deceased alive on 9/26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M.N. AL-MUMAVEZ				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-26-68			
22d. PHYSICIAN'S NAME (Type) M.N. AL-MUMAVEZ, MD		22e. ADDRESS GBMC 6701 N. CHARLES ST. BALTON MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-28-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Shoukri Strong 3207 4th Ave				25a. REC'D BY REGISTRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

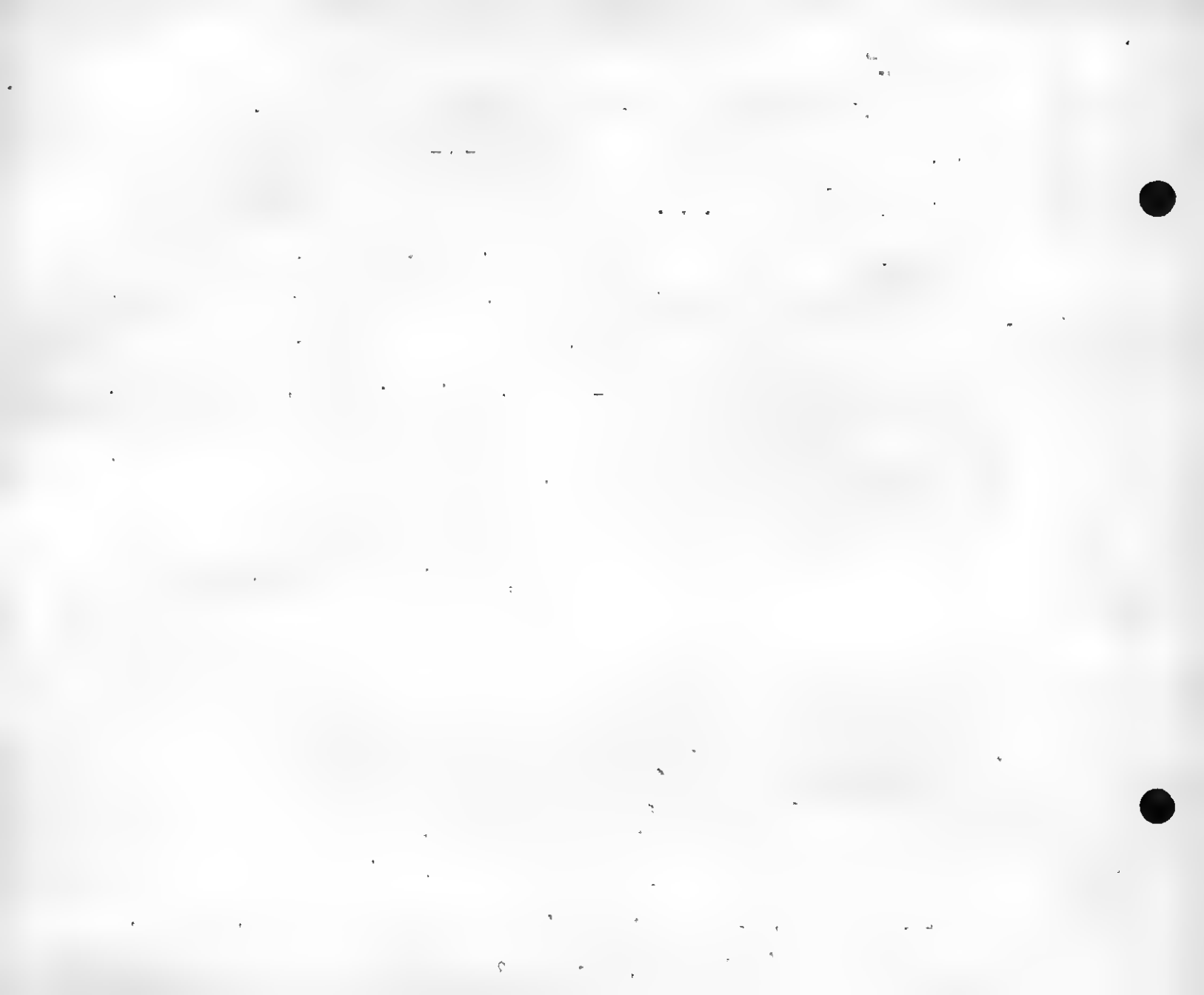
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12502 CERTIFICATE OF DEATH 12512											
1. DECEASED-NAME (Type or print) WILLIAM				First A. Middle BRUNAUGH Last				2a. DATE OF DEATH Month 12 Day 1968		2b. HOUR 11 A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH April 27, 1900.			6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
1d. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Horticulturist			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7709 Fredkert Avenue			
14. FATHER'S NAME First ? Middle Brunaugh Last				15. MOTHER'S MAIDEN NAME First Minta M. Middle Burkes Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown Yes		(If yes give dates of service) WW2		16b. SOCIAL SECURITY NO. 127-01-4500		17. INFORMANT Mrs. Edith M. Brunaugh		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic CVD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4. x. v.											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year — 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —				21f. LOCATION Street or R.F.D. No. City or Town County State —					
22a. I certify that (I) (this hospital) attended the deceased from 4-1, 1958 , to 8-13, 1968 , that (I) (we) last saw the deceased alive on 8-13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Schleris				DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 9-10-68			
22d. PHYSICIAN'S NAME (Type) Sidney Scherlis, M.D.				22e. ADDRESS 11 E. Chase St. Balto., Md. 21202							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/16/68.		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Rayville, Md.				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR SEP 13 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
12503		CERTIFICATE OF DEATH						12513					
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Eleanor			M.		Brunings				Month 9 Day 29 Year 1968		3.15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		1-18-1886				80 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Ohio Cincinnati		U.S.A.						Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Lutherville			College Manor Inc.				Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Charles & 33rd Streets				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME				
			Meyrahl				Eleanor		Meyrahl				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT								
No			213-01-2553		Dr. Karl J. Brunings, Scarsdale, N.Y.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) _____										Days			
5700 DUE TO, OR AS A CONSEQUENCE OF										Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Arteriosclerotic heart disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No.							
22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to _____, 19____, that (I) (we) saw the deceased alive on 9-28-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
RK Gundry MD			9-30-68			R K GUNDY			2 W University Pkwy				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			10-1, 1968		Lorraine Park Cemetery			Woodlawn, Balto., Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204						DATE OCT 2 1968		Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12504

12514

1 DECEASED-NAME (Type or print) ELEANORE L. BRUNT			2a. DATE OF DEATH Month SEPTEMBER Day 4 Year 1968			2b. HOUR 11:56 AM			
3 SEX female		4 RACE white		5. DATE OF BIRTH August 31, 1913		6. AGE (In years last birthday) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Phila., Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		MD	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 106 Osborne Ave.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) school teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 106 Osborne Ave.	
14. FATHER'S NAME First Middle Last Clement Biddle Lewis				15. MOTHER'S MAIDEN NAME First Middle Last Barbara Lou Stover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 219-38-4005		17. INFORMANT Mr Cover S. Brunt		Address 106 Osborne Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 174x DUE TO, OR AS A CONSEQUENCE OF General Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 months (b) 2 year DUE TO, OR AS A CONSEQUENCE OF Carcinoma left breast (c) 170x									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 170x		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/26 , 19 49 , to 9/4 , 19 68 , that (I) (we) lost saw the deceased alive on 9/5 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eliot W. Johnson				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/5/68			
22d. PHYSICIAN'S NAME (Type) Dr. Eliot W. Johnson				22e. ADDRESS 3432 Frederick Ave Baltimore Md 21209					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Sept. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Sterling Funeral Estate		ADDRESS 786 Edmondson Ave.		25a. REC'D BY REGISTRAR SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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12505

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12515

1 DECEASED NAME (Type or print) P. Lewis Bubb			2a. DATE OF DEATH Sept. 17 Month 17 Day 1968			2b. HOUR 8A M				
3 SEX M		4 RACE W		5 DATE OF BIRTH Aug. 16, 1898		6 AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				
10. CITY OR TOWN OF DEATH Parkton			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Armacost Rd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Welder			12b KIND OF BUSINESS OR INDUSTRY Cow Shop	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.			13b COUNTY Balto.			13c CITY OR TOWN Parkton			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER Armacost Rd.										
14. FATHER'S NAME Albert Bubb			15. MOTHER'S MAIDEN NAME June Etta Carr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO 217-20-6363			17 INFORMANT Mrs. Naomi A. Bubb, Armacost Rd, Parkton, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) G.I. & R. disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 222										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 68 , to 9/17 , 19 68 , that (I) (we) last saw the deceased alive on 9/17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. M. France						22c. DATE SIGNED 9/17/68				
22d. PHYSICIAN'S NAME (Type) A. M. FRANCE						22e. ADDRESS PARKTON, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9-20-68		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Parkton, Balto., Md.		
24. FUNERAL DIRECTOR James J. Hartenstein, New Freedom Pa						25a. REC'D BY REGISTRAR SEP 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

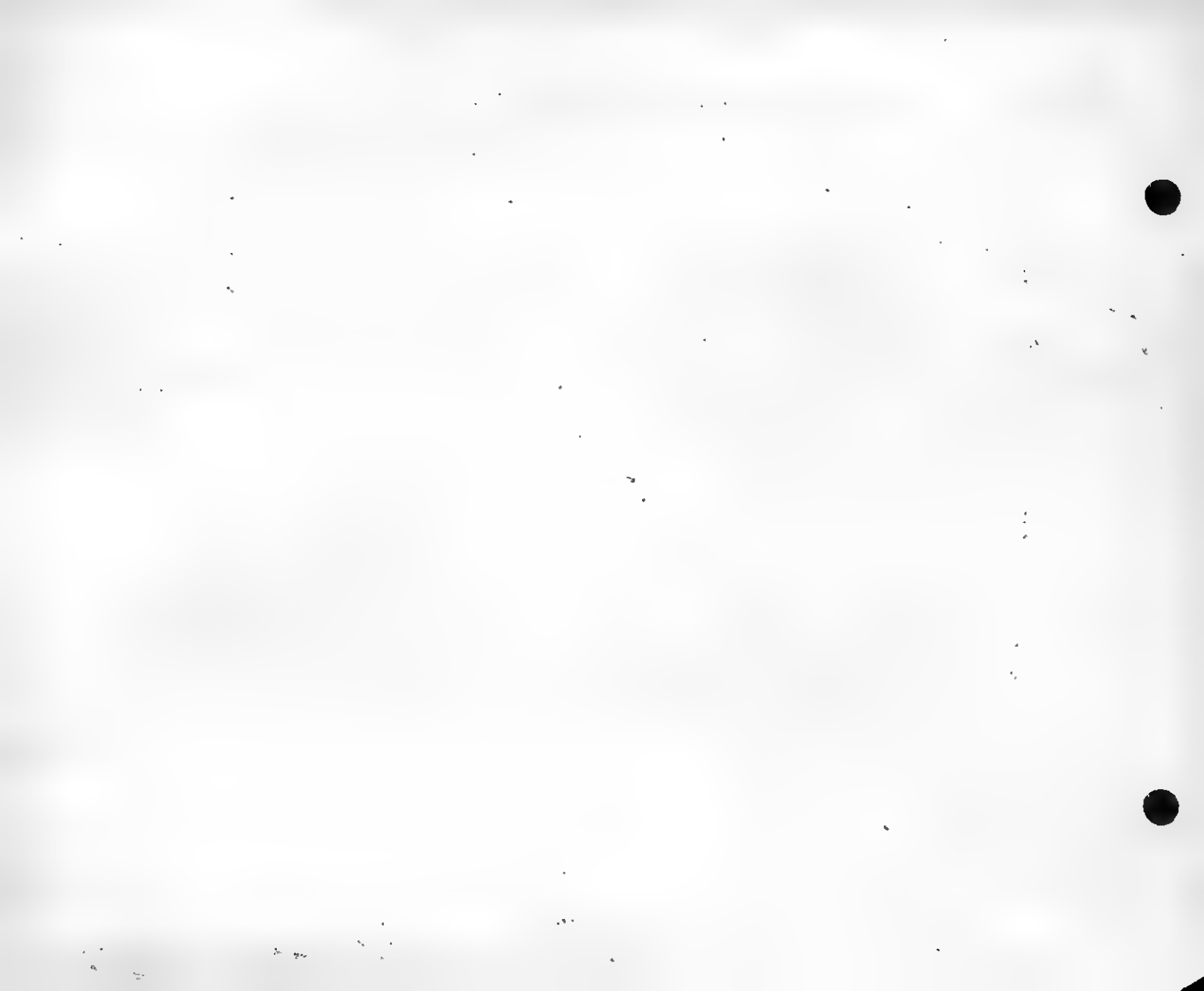


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Retained for photo by Dr. P.D. Coffey

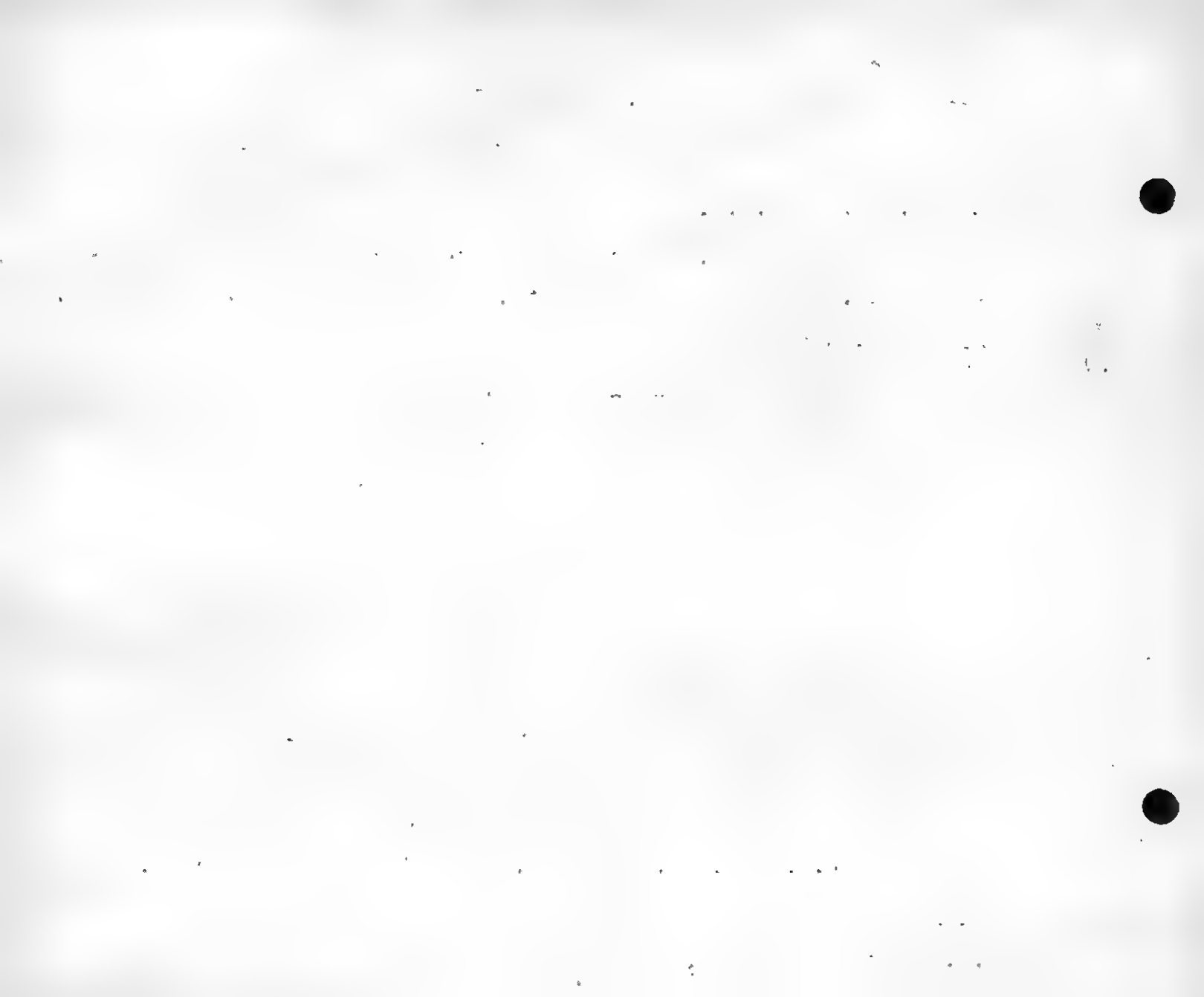
12506		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12516	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
George Washington Buckman		Apr 24 1968		DOA M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
M	W	Nov. 6, 1880	87 YRS		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
Pikesville			Sign Painter	Standup Oil	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
md	Baltimore	Pikesville		104 Sherwood Ave 21208	
14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last				
John Buckman	Anna Fox				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address		
NO	216-22-4358	daughter Mrs Edith Williams	21208 417 Milford Mill Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.V.A.					
4127 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause					
(b) A.S.C.V.D.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
T.X.I.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
	19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-5, 1968, to , 19 , that (I) (we) lost saw the deceased alive on May 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Williams M.D.			22c. DATE SIGNED 9-24-68		
22d. PHYSICIAN'S NAME (Type) Charles H. Williams, M.D.			22e. ADDRESS Pikesville, 21208, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
Burial	Sept. 27, 1968	St. Thomas Cemetery	Baltimore		
24. FUNERAL DIRECTOR	ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Frank H. Newell	Pikesville, Md.		SEP 26 1968	Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12507		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12517	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Conrad G. Buedel				2a. DATE OF DEATH Month Day Year September 30, 1968		2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH 5/13/1889		6. AGE (In years last birthday) YRS 79	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ches. Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) President - Steel & Wire Prod. Inc.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 3900 N. Charles St.	
14. FATHER'S NAME First Middle Last Frederick Buedel				15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Fuchs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO 216-07-9486		17. INFORMANT Address Mrs. Margaret P. Buedel (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Stroke DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerotic Changes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 1967 to Sept 30, 1968 , that (I) (we) last saw the deceased alive on Sept 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles E. Carr, Jr.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 10/1/68	
22d. PHYSICIAN'S NAME (Type) Dr. Charles E. Carr, Jr.				22e. ADDRESS 3900 N. Charles St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/3/1968		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Road Balto., Md.		25a. REC'D BY REGISTRAR OCT 1 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12508

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12518

1 DECEASED-NAME (Type or print) CORA First M. Middle BURNS Last			2a DATE OF DEATH 9 Month 7 Day 68 Year			2b. HOUR 12¹⁰ A M					
3 SEX FEMALE		4 RACE W		5 DATE OF BIRTH April 12, 1879		6 AGE (in years lost birthday) 89 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH Baltimore 21228			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5220 Old Frederick Rd.		
14. FATHER'S NAME First Middle Last Mitchell			15. MOTHER'S MAIDEN NAME First Middle Last unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Marlene Crowetz, 5220 Old Frederick Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOLENERGIC CARDIO-VASCULAR DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 8/15, 1968 to 9/7, 1968 , that (I) (we) lost saw the deceased alive on 9/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John H. Shaw M.D.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/9/68			
22d. PHYSICIAN'S NAME (Type) John H. Shaw M.D.						22e. ADDRESS 5801 EMBLETTON AVE APT. 28, WILM.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR G. Truman Schwab, 5151 Balto. Natl. Pike, Baltimore, Maryland, 21229						25a. REC'D BY REG STRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

12509

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12519

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR		
HELEN				BURT	September 12 1968		10:34 PM		
3. SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE	WHITE		March 18, 1916		52 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL		HOUSEWIFE					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		BALTO		BALTO. 21220				RT. 14, BOX 129	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
ANTHONY		ZIELINSKI							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		213-01-2815		EDWARD BURT		ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u>									
5718 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5812 (b) <u>Portal cirrhosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Gastro-intestinal hemorrhage due to esophageal varices</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town	
								County	
								State	
22a I certify that (I) (this hospital) attended the deceased from <u>SEPT. 11, 1968</u> , to <u>SEPT. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Ines Cilliani						9/13/68			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Ines Cilliani, M.D.		7620 York Rd., Towson, Md. 21204							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		9/16/68		GARDENS OF FAITH		BALTO. MD			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.G. CONNELLY SONS		300 MALE		SEP 19 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12510 Items 5, 13, 14 & 15 12520											
1 DECEASED NAME (Type or print)						2a DATE OF DEATH			2b HOUR		
BABY BOY BURTON						Month 9 Day 13 Year 1968			9:50p M		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS.	
Male		Caucasian		September 12, 1968		YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		USA				Baltimore Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				-		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		2825 Clearview Ave. 21234	
14 FATHER'S NAME First Middle Last			15. MOTHER'S M.A.DEN NAME First Middle Last								
James Parker Burton			Belinda Darlene Peary								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Prematurity</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Premature rupture of maternal membranes</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
1615											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 9/11, 1968, to 9/13 1968, that (I) (we) last saw the deceased alive on 9/13 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>John E. Adams, M.D.</u>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 9/15/68			
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.				22e. ADDRESS Greater Baltimore Medical Center							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 9-16-68		23c NAME OF CEMETERY OR CREMATORY Greater Balto Med Ctr		23d LOCATION (City or Town) Towson		(County)		(State) Md.	
24. FUNERAL DIRECTOR John E. Adams, M.D.				ADDRESS GPMC		25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12511

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12521

1. DECEASED-NAME (Type or print) Harry Preston Burton			2a. DATE OF DEATH Month 9 Day 30 Year 68			2b. HOUR M 	
3 SEX M		4 RACE Cauc.		5 DATE OF BIRTH Aug. 18 1894		6 AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Lutherville, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Lutherville, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1434 Burton Ave.		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJA. RES DENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 1434 Burton Ave.		14 FATHER'S NAME First William Middle Burton Last Burton		15 MOTHER'S MAIDEN NAME First ? Middle Cockey Last #			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes W.W.II		16b. SOCIAL SECURITY NO 218 05 1729 #		17 INFORMANT Esther C. Burton		Address 1434 Burton Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 5 minutes 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary atherosclerosis 2 years DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1957 to Sept 30, 1968 , that (I) (we) last saw the deceased alive on Sept 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE George T. Gilmore, M.D.				22c. DATE SIGNED Oct 1, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. George T. Gilmore, M.D.				22e. ADDRESS Lutherville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 3, 68		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City or Town) (County) (State) Towson, Md. Baltimore	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204				25a. REC'D BY REGISTRAR DATE OCT 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12512		12522									
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH		2b. HOUR	
JAMES CALDWELL								Month 9 Day 12 Year 68		4:45A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		NEGRO		8/1/24		44 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
CHESTER, SOUTH CAROLINA		U.S.A.				BALTIMORE COUNTY, Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VET. ADM. HOSPITAL		LABORER		CONSTRUCTION					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution on admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, J.M. 157		13e. STREET AND NUMBER	
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1529 LEXINGTON STREET	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
ROBERT E. CALDWELL				MARY E. KNOX							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES		WW II		249 28 21 32		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1977 CARCINOMATOSIS UNDIFFERENTIATED TYPE (ORIGIN UNKNOWN) 4 MONTHS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		NO AUTOPSY					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (this hospital) attended the deceased from 6/24/68, 19____, to 9/12/68, 19____, that (we) last saw the deceased alive on 9/12/68, 19____, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Nan Ann Orer M.D.										9/12/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
INFAN A. ORER, M. D.				VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		9/16/68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				GILMORE FUNERAL HOME		SEP 13 1968		J. Charles Judge			
				1827 W. North Ave. Baltimore, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12513

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12522

1. DECEASED-NAME (Type or print) Mary Arden Cates			2a. DATE OF DEATH Sept. Month 23 Day 19 Year 1958			2b. HOUR 9:30 PM			
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Sept. 7, 1882		6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Lutherville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) College Manor, Inc.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. LSLAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY ***		13c. CITY OR TOWN Baltimore		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 100 Tuscany Rd. 21210	
14. FATHER'S NAME John W. Randall			15. MOTHER'S MAIDEN NAME Hanna Parrot						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-24-8026		17. INFORMANT Upshur Lowndes Md. National Bank					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Myocardial failure Pulmonary Edema 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 or 5 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 23, 1958 , to Sept 23, 1958 , that (I) (we) lost saw the deceased alive on Sept 23, 1958 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph G. Hills M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Sept 24 1958			
22d. PHYSICIAN'S NAME (Type) Ralph G. Hills, M.D.				22e. ADDRESS 18 E. Eager St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Sept. 22, 68		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.				25a. REC'D BY REGISTRAR SEP 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 72 hours after death.

1

12514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12521

1. DECEASED NAME (Type or print) First Middle Last Justa McV Chalk			2a. DATE OF DEATH Month Day Year 9 24 68			2b. HOUR 8:25 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH 3-1-89		6. AGE (in years last birthday) 79 YRS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Garrison		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foxleigh		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY -		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2005 Oakington St.							
14. FATHER'S NAME First Middle Last Howard McVeigh			15. MOTHER'S MAIDEN NAME First Middle Last Lilly Snyder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 220-09-0018		17. INFORMANT John Chalk, Jr.		Address 4106 Buena Vista Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 410X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-1-68, 19 to 9-24, 1968, that (I) (we) last saw the deceased alive on 9-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Vicente M. Ruado				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-24-68	
22d. PHYSICIAN'S NAME (Type) VICENTE M RUADO				22e. ADDRESS Spring Grove Hosp			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-27-68		23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cem		23d. LOCATION (City or Town) (County) (State) Warren Baltimore MD	
24. FUNERAL DIRECTOR Burger Funeral Home Balto Md				25a. REC'D BY REGISTAR SEP 27 1968		25b. REGISTRAR'S SIGNATURE	



12515

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) DAVID W CHERKOF			2a DATE OF DEATH Month Sept Day 17 Year 1968		2b HOUR 7A M
3. SEX MALE	4. RACE CAUCASIAN		5. DATE OF BIRTH OCT 30, 1883		6. AGE (In years last birthday) 84 YRS
7a BIRTHPLACE (State or foreign country) Russia		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto Md.
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Mtford Manor Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Real Estate	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md		13b. COUNTY Balto	13c CITY OR TOWN Balto	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 4406 Springdale Ave
14. FATHER'S NAME First Chana Middle Cherthof Last Elegen		15. MOTHER'S MAIDEN NAME First Elegen Middle Elegen Last Elegen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No		16b. SOCIAL SECURITY NO. 43007		17. INFORMANT Jack Cherthof 7803 Ridge Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BASILAR ARTERY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 331X					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo 5
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1966 to Sept 17, 1968 , that (I) (we) last saw the deceased alive on Sept 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph Shear M.D.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 9/17/68	
22d. PHYSICIAN'S NAME (Type) Joseph Shear M.D.		22e. ADDRESS 6715 PARK HEIGHTS AVE BALTO MD			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/18/68		23c NAME OF CEMETERY OR CREMATORY Chapel Ameno	
23d. LOCATION (City or Town) (County) (State) Balto md		23e. REC'D BY REGISTRAR Sylvan S. Lewis & Son, INC 9610 Reisterstown Rd			
24 FUNERAL DIRECTOR Sylvan S. Lewis & Son, INC		25a. DATE SEP 19 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

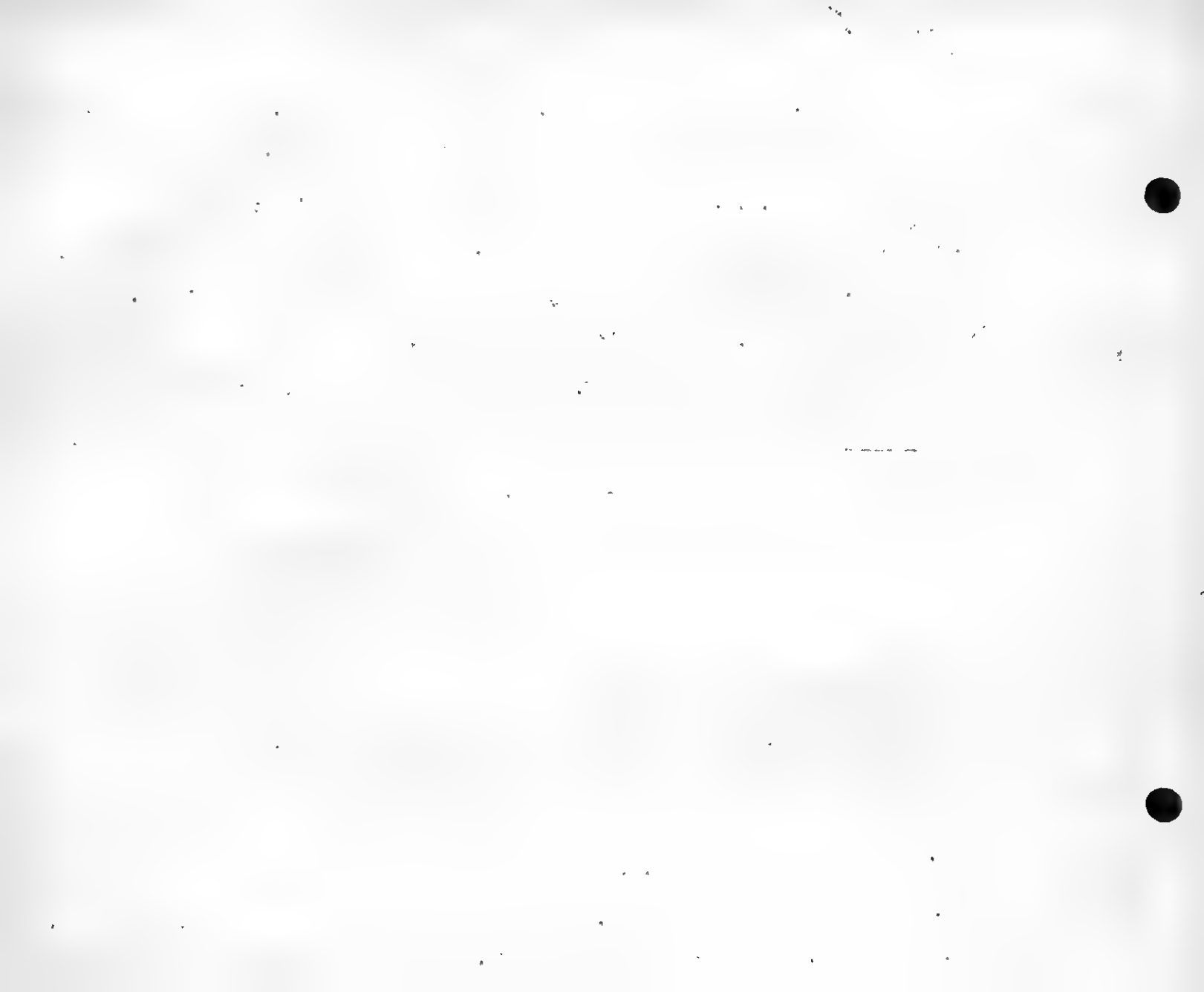
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12516										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12526																													
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										2b. HOUR																													
Roland Childs										Sept. 25 1968										4:17 M																													
3 SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
male										white										April 23 1890										78 YRS.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md									
Maryland										U.S.A.																				Baltimore																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
Catonsville										Shady Nook N.M.										retired										Farming																			
13a. USUAL RESIDENCE (Where deceased admission) STATE										13b. CITY OR TOWN										13c. INSIDE CITY L.M.T.P. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Howard										Highland										Brown Bridge Rd.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
First Middle Last										First Middle Last																																							
Theodore E. Childs										Emma Umstead																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO										17. INFORMANT										Address																			
No										218 36 2672										Martha Childs										Highland, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE (a)										Pneumonia																				4 days																			
DUE TO, OR AS A CONSEQUENCE OF																																																	
(b)										Anterograde cerebral-cardiovascular disease																				6 months +																			
DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
334x																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 7-15-68 to 9-25-68, that (I) (we) last saw the deceased alive on 9-25-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										22c. DATE SIGNED																																							
John A. Nesbitt M.D.										9-27-68																																							
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																							
John A. Nesbitt M.D.										1009 Frederick Ave, Catonsville, Md.																																							
23a. BURIAL CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										9/28/68										St. John										Olney Montgomery, Md.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Higinbotham Slack										Ellicott City, Md.										OCT 1 1968										Charles Judge																			

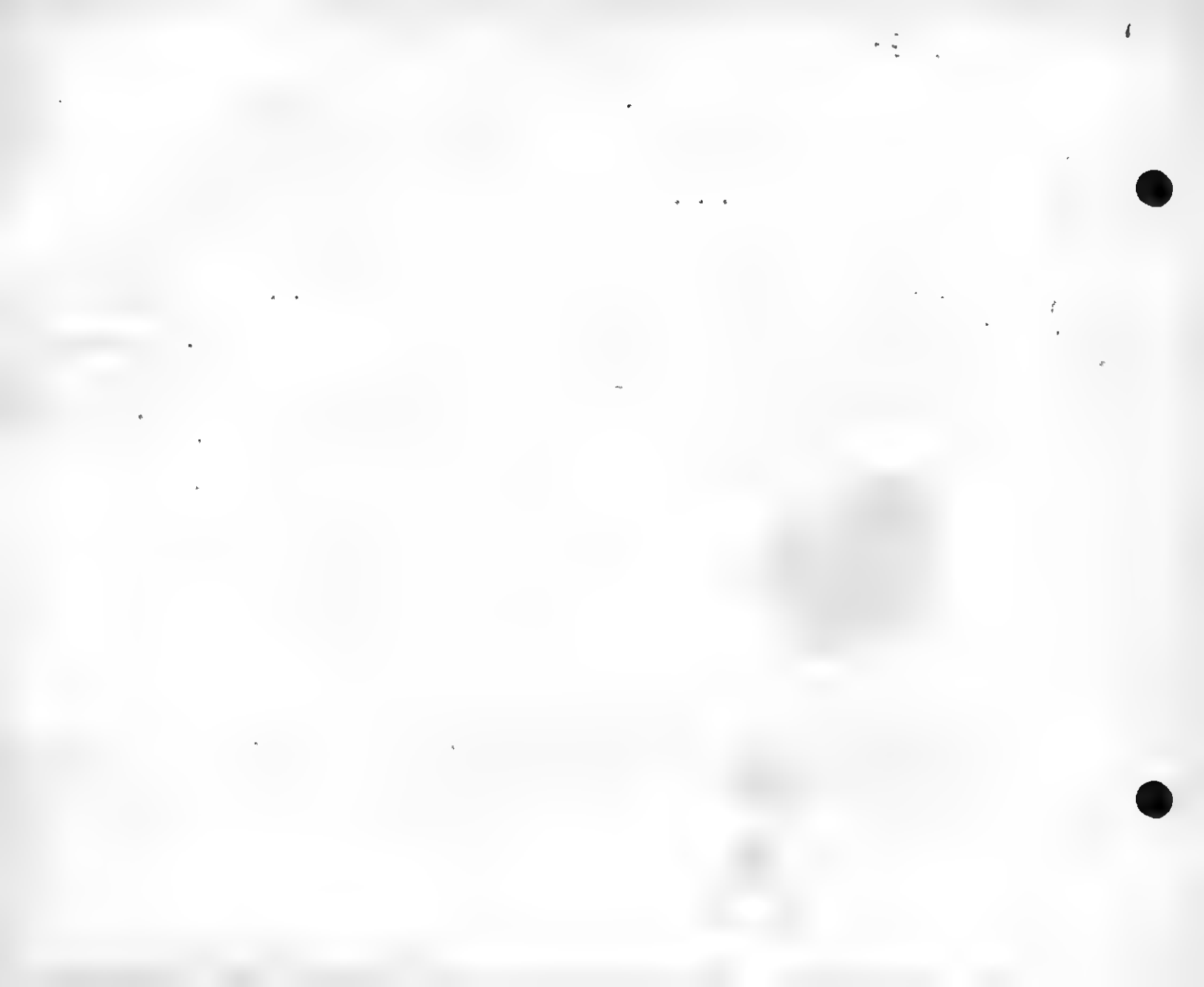


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV

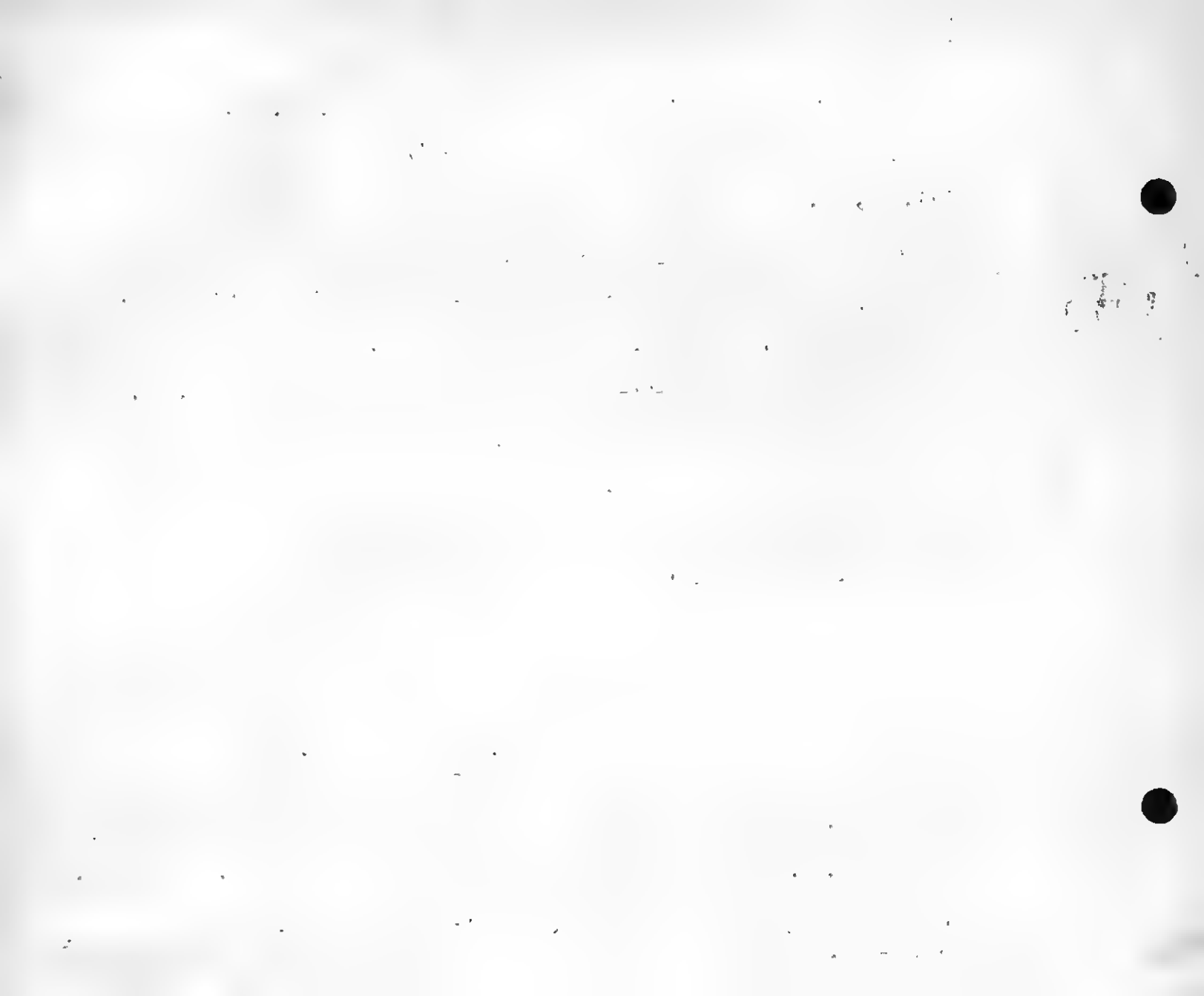
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Louis		A.	Clayman	September 30, 1968		6:00 M			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white		October 14, 1886		81 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maine		U.S.A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Spring Grove State Hospital		Salesman					
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER			
Maryland		Prince George		Brandywine		R.R.#2, Box 198-A			
14. FATHER'S NAME (dec'd) Philip		First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last		UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
		182-01-3307A		Records: Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) with irretractable heart fail									
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic, Cardiovascular, Ht. Dis. 1 wk.									
4127 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized, senile. 20 yrs.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4127									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1968, to Sept. 30, 1968, that (I) (we) last saw the deceased alive on Sept. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
Anthony J. Young, M.D.		9-30-68			22e. ADDRESS				
					SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		10-1-68		CEDAR HILL		WASHINGTON DC			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE			
BERNARD DANZANSKY & SONS WASH. DC.		OCT 3 1968		f Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Edward John Cleary						2a. DATE OF DEATH Month Day Year Sept. 19, 1968			2b. HOUR 11:30		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/29/1888		6. AGE (In years lost birthday) 79 YRS		7. FUNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) file setter			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIM-ITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6643 Frederick Rd.			
14. FATHER'S NAME First Middle Last James H. Cleary				15. MOTHER'S MAIDEN NAME First Middle Last Anne E. Meara							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-01-9865A		17. INFORMANT Address Hospice Records, Towson, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 <u>Bronchogenic Carcinoma - cerebral metastases.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchitis & emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCUD - old MI.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCUD - old MI.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos - 4 yrs -	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/15/68</u> , 19____, to <u>9/19/68</u> , 19____, that (I) (we) last saw the deceased alive on <u>9/19/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Lee Robbins				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/19/68			
22d. PHYSICIAN'S NAME (Type) Dr. E. Lee Robbins				22e. ADDRESS Court House Square Apt. Towson, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/68		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore					
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.				ADDRESS 6500 York Road. 21212		25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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12519

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film 107-2331-105
CERTIFICATE OF DEATH

12529

1. DECEASED-NAME (Type or print) First Middle Last Wiley Ray Coffman			2a. DATE OF DEATH Month Day Year 9 26 1968		2b. HOUR M
3 SEX Male	4 RACE Cau.	5 DATE OF BIRTH 9-22-1896	6 AGE (In years lost birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Fairmont W.Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Middle River	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2101 Orem's Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Self employed	12b. KIND OF BUSINESS OR INDUSTRY Restuarant		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY OR TOWN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2101 Orem's Road 21220	
14 FATHER'S NAME First Middle Last Arthur Coffman	15 MOTHER'S MAIDEN NAME First Middle Last Emma M. Dowds				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	(If yes give year or dates of service) W.W.I	16b. SOCIAL SECURITY NO. 232-05-2177	17. INFORMANT Mrs Opal Coffman 2101 Orem's Road 21220		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mo.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 1621		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May , 1968, to Sept 26 , 1968, that (I) (we) last saw the deceased alive on Sept 26 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Louis Semenov		DEGREE MD		22c. DATE SIGNED 9/27/68	
22d. PHYSICIAN'S NAME (Type) LOUIS SEMENOV		22e. ADDRESS 2108 OREMS RD, BALTO MD 21220			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-28-1968	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Bel Air Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236		25a. RECD BY REG STRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR OF DEATH	
Edith Price Cole						Sept 6 1968		12:30	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
female		white		June 28, 1890		78 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson, Md.		Dulaney Towson Nursing Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution Res.dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Baltimore		Towson				7724 Greenview Terrace	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Eljah Price						Florence Chilcoat Price			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No			220-445605		Dulaney Towson Nursing Home		111 West Road		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Competitive Cardio Vascular Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from Jan 10, 1968, to Sept 6, 1968, that (I) (we) last saw the deceased alive on Sept 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		22c DATE SIGNED							
Lawrence C. Post M.D.									
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
LAWRENCE C. POST									
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Sept. 9, 1968		Forest Baptist		Baltimore Co. Md.			
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson, Towson, Md. 21204						DATE SEP 9 1968		Charles Judge	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or print)			First Elizabeth			Middle B.			Last Coleman			2a DATE OF DEATH Month Day Year September 17, 1968			2b HOUR 10:15 M		
3. SEX F			4. RACE W			5. DATE OF BIRTH Jan. 21, 1891			6. AGE (in years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a BIRTHPLACE (State or foreign country) Norfolk, Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md.					
10. CITY OR TOWN OF DEATH Stevenson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stewart Rd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Baltimore			13c CITY OR TOWN Stevenson			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Stewart Rd.					
14. FATHER'S NAME First Middle Last William T. Brooke			15. MOTHER'S MAIDEN NAME First Middle Last Mary Goode														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIA. SECURITY NO (If yes give war or dates of service)			17 INFORMANT Miss Susan N. Coleman			Address (Same)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last coronary failure (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF coronary failure (c) coronary failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 6 years 6 months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION 9/17/68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 1968 to Sept 17, 1968 , that (I) (we) lost saw the deceased alive on Sept 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE Palmer F. C. Williams M.D.			22c. DATE SIGNED Sept 18, '68			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (Type) Dr. Palmer F. C. Williams			22e. ADDRESS Owings Mills, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 9/20/68			23c NAME OF CEMETERY OR CREMATORY St. Thomas			23d LOCATION (City or Town) (County) (State) Garrison Forest, Balto. Co., Md.								
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR DATE SEP 23 1968			25b REGISTRAR'S SIGNATURE J. Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/55

MEDICAL CERTIFICATION

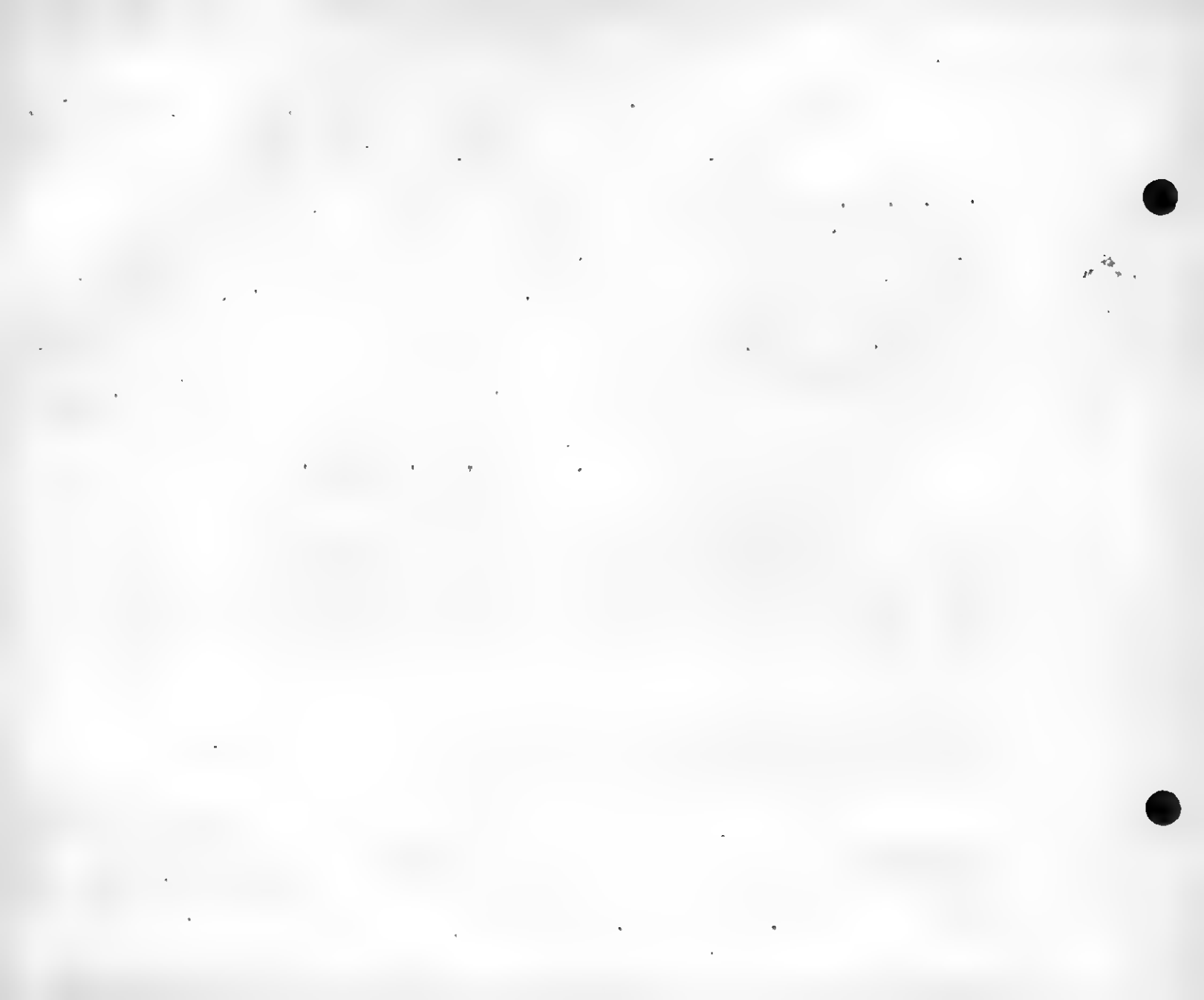
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH	Month	Day	Year	2b HOUR
Mary			M.	Collins	September	23	1968	8:00 AM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	White	Sept. 23, 1872		96 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.	U.S.			Baltimore Co. Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Reisterstown		Bent Nursing Home		Laundress		LAUNDRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Anne Arundel		Annapolis				139 Charles St.	
14 FATHER'S NAME		First	Middle	Last	5. MOTHER'S MAIDEN NAME		First	Middle	Last
James		R.	Brockett		Ellamar				Corbin
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
no		216-12-8085		ANDREW M. Collins		Annapolis MD.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u>								Minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis -</u>								Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u>								Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>260x</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> , 19 <u>67</u> , to <u>Sept 23</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Sept 19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Charles E. Williams</u>					DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <u>9-23-68</u>		
22d PHYSICIAN'S NAME (Type)					22a ADDRESS <u>11904 Reisterstown Rd Reisterstown Md</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		9-25-68		CEDAR BLUFF		ANNAPOIS		A.A.	MD.
24 FUNERAL DIRECTOR <u>John M. Lykasus</u>					ADDRESS <u>Annapolis Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 26 1968</u>		25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ALBERT		Middle M.		Last COOK		2a. DATE OF DEATH Month September Day 14, 1968 Year 1968		2b. HOUR 9 a. M.						
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH November 28, 1921			6. AGE (In years last birthday) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign Baltimore, Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore 4 Md.								
10. CITY OR TOWN OF DEATH Towson 4			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if not at an admission) STATE Maryland			13b. COUNTY HALL			13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Hess Road - 21047						
14. FATHER'S NAME First Harry			Middle M.		Last Cook		15. MOTHER'S MAIDEN NAME First Lottie			Middle M.		Last Shaffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes, give dates of service) Yes			16b. SOCIAL SECURITY NO 219-14-8519			17. INFORMANT Mrs. Ruth F. Cook			Address Cockeysville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral encephalomalacia																	
DUE TO, OR AS A CONSEQUENCE OF cerebral vascular hypoplasia																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
332x																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from September 13, 1968, to September 14, 1968, that (I) (we) last saw the deceased alive on Sept. 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ines Cilliani, M. D.												DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Sept. 14, 1968			
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M. D.												22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 17, 68			23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery			23d. LOCATION (City or Town) (County) (State) Upperco, Md.								
24. FUNERAL DIRECTOR J. F. Elise & Sons												ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12524		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12534	
1 DECEASED NAME (Type or print) MARY			First MARY Middle Howley Last COONEY			2a. DATE OF DEATH 9 Month 5 Day 1968	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5/12/1886		6. AGE (in years) 82 YRS	
7a BIRTHPLACE (State or foreign country) Floyd Co. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH CATONSVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in The Pines		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY At Home	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME John		First John Middle B. Last Howley		15 MOTHER'S MAIDEN NAME WATKINS		First WATKINS Middle WATKINS Last WATKINS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 217-20-5409A		17 INFORMANT Mrs. Frank B. Durrigg		Address 4204 Barrington Rd. Balt. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF (b) degeneration of age DUE TO, OR AS A CONSEQUENCE OF (c) Mitral insufficiency & compensation							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4129							
19a. DATE OF OPERATION 4-9-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 1960 to Sept 1968 , that (1) (we) last saw the deceased alive on Sept 13 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B.B. Brumbaugh MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/68	
22d. PHYSICIAN'S NAME (Type) B.B. Brumbaugh				22e. ADDRESS 1609 Main St Edinburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-9-1968		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.	
24. FUNERAL DIRECTOR Wm. Mullen				RECD BY REGISTRAR Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12525

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12535

1. DECEASED-NAME (Type or Print)			First JOHN			Middle E.			Last CORNELL			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9/24 19 68			2b. HOUR 4:20 A.M.				
3. SEX male		4. RACE white		5. DATE OF BIRTH 6/22/1881		6. AGE (in years last birthday) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month September Day 24, Year 19 68			2d. HOUR 4:20 A.M.				
7a. BIRTHPLACE (State or foreign country) Pa.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Unknown				12b. KIND OF BUSINESS OR INDUSTRY Unknown			
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1224 W. Hollins St.					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO (If yes give war or dates of service) Unknown						17. INFORMANT ADDRESS Balto. Md. Mrs. Frankie Lamar - 1224 Hollins St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Right Hip</u> 814.7 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
Arteriosclerotic Cardiovascular Disease																			
19a. DATE OF OPERATION 9/16/68						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? pedestrian struck by car						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 6:00 P.M. 9/16 19 68						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) pedestrian struck by car							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street						21f. LOCATION Street or R.F.D. No City or Town County State Baltimore, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 9/24/68							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9/27/1968				23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.				23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.							
24. FUNERAL DIRECTOR John J. Cowan + Son Inc. 901 Hollins St.						25a. REC'D BY REGISTRAR DATE SEP 27 1968						25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12526 CERTIFICATE OF DEATH 12536									
1 DECEASED NAME (Type or print)			First Middle Last ELEANOR S. COTTON			2a. DATE OF DEATH Month 9 Day 11 Year 68		2b. HOUR 10 P.M.	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH 12-3-1889		6 AGE (in years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTH-PLACE (State or foreign country) New Jersey		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		Md.	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sect.		12b. KIND OF BUSINESS OR INDUSTRY Art			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5336 Midwood Ave	
14. FATHER'S NAME First Middle Last Joseph M. Brineshults			15. MOTHER'S MAIDEN NAME First Middle Last Emeline Corneal						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 159 03 7415		17 INFORMANT Chas. H Brineshults 5336 Midwood Ave					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COMPLETE HEART BLOCK DUE TO, OR AS A CONSEQUENCE OF 4107 (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1201 CORONARY THROMBOSIS									
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from OCT 10, 1968 to SEPT 11, 1968, that (I) (we) last saw the deceased alive on SEPT 11, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Laurence C. Post M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-11-68			
22d. PHYSICIAN'S NAME (Type) LAURENCE C. POST, M.D.				22e. ADDRESS 6805 YORK ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 9/16/1968		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24 FUNERAL DIRECTOR Mitchell Wiedefeld Home				ADDRESS 6500 York Rd.		25a REC'D BY REGISTRAR DATE SEP 16 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 404 9-17-68 MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12527 CERTIFICATE OF DEATH 12537									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary L. Cottrell						Month 9 Day 6 Year 1968			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Cau.		4-20-1946			22 YRS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Middle River			922F. Holgate Drive			Secretary			C.P. Tel. Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm-ssion) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM-ITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Baltimore		Middle River				922F. Holgate Drive 21
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Caldwell			Lillian E. Gunter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) No			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
			218-44-0132		Mrs Lillian Caldwell Bond 605 Hyde Park Rd 21221				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARCINOMATOSIS									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) CARDIAC FAILURE									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Malignant melanoma - skin of back.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1105									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		CARCINOMA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 6 SEPT. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 2 30 AM 9-6-68									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
Ronald H. Fishbein M.D.						9-6-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
RONALD H. FISHBEIN M.D.		220 W. COLD SPRING LANE, BALT 21210							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-9-1968		Oak Lawn Cemetery		Baltimore Co. Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lassahn Funeral Home		7401 Belair Road 21236		DATE SEP 9 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

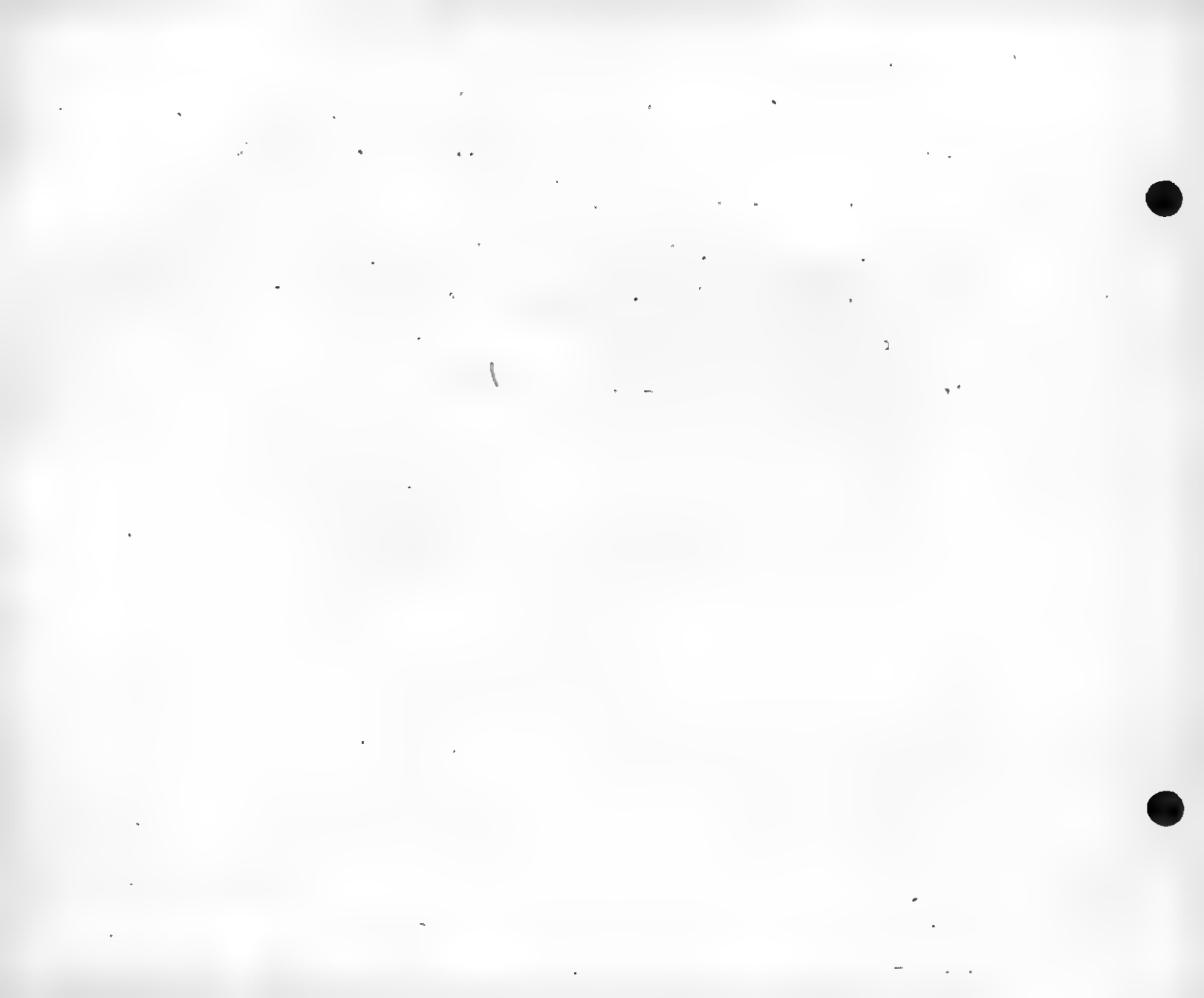
12528		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12538	
Item #6 Film #G404 9/18/68 vmp					
1. DECEASED-NAME (Type or print) First Middle Last RODNEY L. CRAWFORD			2a. DATE OF DEATH Month 9 Day 11 Year 68		2b. HOUR 11:55 pm
3 SEX MALE	4. RACE Cauc.	5. DATE OF BIRTH Oct. 23, 1893		6. AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Westernport, Md.	7b. CIT ZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH BALTO., MD.	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) GREATER BALTO., MED. CEN.	12a. USJA. OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto	13c. CITY OR TOWN Marbel Hall Rd.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last William H. Crawford		15. MOTHER'S MAIDEN NAME First Middle Last Catherine A. Peters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4299 ACUTE PULMONARY EDEMA RECURRENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF SEC. TO HEART DISEASE (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4344					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 68 , to 9/11 , 19 68 , that (I) (we) last saw the deceased alive on 9/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gihan TenneKoon		DEGREE MD.		22c. DATE SIGNED 9/11/68	
22d. PHYSICIAN'S NAME (Type) GIHAN TENNEKOON MD.		22e. ADDRESS Greatr Baltimore Md. Cntr.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 14, 68	23c. NAME OF CEMETERY OR CREMATORY New Freedom		23d. LOCATION (City or Town) (County) (State) New Freedom, Pa.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Wilfred		Middle H.		Last Crawford		2a. DATE OF DEATH Month Sept Day 10 Year 1968		
3 SEX male		4 RACE white		5 DATE OF BIRTH Nov. 28, 1909			6 AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0
7a BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) real estate			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.		13c CITY OR TOWN Rodgers Forge		13d. NSIC CITY LIM-757 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 315 Dunbarton Road		
14 FATHER'S NAME First Howard Middle Crawford Last Crawford			15 MOTHER'S MAIDEN NAME First Nell Middle Cutler Last Cutler								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 212-03-5198HA		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA - CHRONIC RENAL FAILURE 403X DUE TO, OR AS A CONSEQUENCE OF (b) NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) ARTERIOSCLEROSIS GENERALIZED										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL VASCULAR ACCIDENT											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that he (this hospital) attended the deceased from Sept. 19, 1966 , to Sept. 10, 1968 , that (I) (see) last saw the deceased alive on Sept. 10 , 1968, and that in (my) (see) opinion death occurred on the date and hour and from the causes stated above, (I) (see) (did) (did not) view the body after death.											
22b SIGNATURE Alberto M. Gutierrez						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED Sept 10, 1968			
22d PHYSICIAN'S NAME (Type) ALBERTO M. GUTIERREZ						22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 9/13/68		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Cem.		23d LOCATION (City or Town)		(County)		(State) Balto. Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks						25a REC'D BY REGISTRAR SEP 13 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print)			First Lyda			Middle			Last Croft			2a. DATE OF DEATH 9-21 Month Day 68 Year			2b. HOUR 4:10 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 12-20-95			6. AGE (In years last birthday) 72 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 434 N. Pulaski St.					
14. FATHER'S NAME First William			Middle Sherman			Last Rachel Elizabeth Price			15. MOTHER'S MAIDEN NAME First Rachel Elizabeth Price								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-48-85128			17. INFORMANT Spring Grove State Hosp. Records											
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 11.7 DUE TO, OR AS A CONSEQUENCE OF Organic brain syndrome with degenerative disease of the central nervous system. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 355X																	
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that He (this hospital) attended the deceased from 7-5 , 1968 , to 9-21 , 1968 , that (I) (we) last saw the deceased alive on 9-21 , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Alexander E. Hernandez			DEGREE MD			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) Alexander E. Hernandez			22e. ADDRESS Spring Grove State Hosp.			22f. ADDRESS Baltimore, Maryland 21228			22g. ADDRESS Black Rock, Balto., Md.								
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial			23b. DATE 9-25-68			23c. NAME OF CEMETERY OR CREMATORY Grace Methodist			23d. LOCATION (City or town) Baltimore, Md. (State)								
24. FUNERAL DIRECTOR Wm. Cook-Brooks Twpson,			ADDRESS 1050 York Rd., Towson, Md.			25a. REC'D BY REG. STRAR SEP 25 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12531

12511

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN IT One Year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 218 Cherry Hill Road			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 218 Cherry Hill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Marion J. Cross			4. DATE OF DEATH September 9 1968		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1917		9. AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furnace Operator		10b. KIND OF BUSINESS OR INDUSTRY Armco Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Peter Cross			14. MOTHER'S MAIDEN NAME Anna Mackow		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-07-4595		17. INFORMANT (Wife) Mrs. Irene Cross, 218 Cherry Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Actual fibrillation (c) Arteriosclerotic coronary artery disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 in 1					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 9/6 19 68 , to 9/9 19 68 , that (I) (we) last saw the deceased alive on 9/6 19 68 , and that death occurred at 8 AM , from the causes and on the date stated above.					
22a. SIGNATURE Philip Bernstein		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/9/68	
22c. PHYSICIAN'S NAME (Type) Philip Bernstein, M.D.		22d. ADDRESS 112 Chartley Drive, Reisterstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/12/68	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda, 2829 Hudson St. Balto. Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 13 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12532 CERTIFICATE OF DEATH 12512											
1. DECEASED NAME (Type or print) DOROTHY M. CRUE						2a. DATE OF DEATH 9 Month 25 Day 68 Year			2b. HOUR PM 1:22		
3. SEX FEMALE		4. RACE CAU		5. DATE OF BIRTH 7/4/19		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALTO. MED. CENTER				12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired.) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY B.D.Mfg. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN TIMONIAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 28 Greenmeadow Drive	
14. FATHER'S NAME First Middle Last David J. CAMPBELL SMITH				15. MOTHER'S MAIDEN NAME First Middle Last Dorothy Fanny Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, state war or dates of service) No				16b. SOCIAL SECURITY NO. 318-32-6277		17. INFORMANT Address Family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RHEUMATOID HEART AND LUNG DISEASE 1125 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATOID ARTHRITIS DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 68 , to 9/25 , 19 68 , that (I) (we) last saw the deceased alive on 9/25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 9/25/68					
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN, M.D.						22e. ADDRESS 6701 NORTH CHARLES STREET 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Sept. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Sherwood Church Cem.				23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.			
24. FUNERAL DIRECTOR John Burton Bone, Towson, Md.						25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



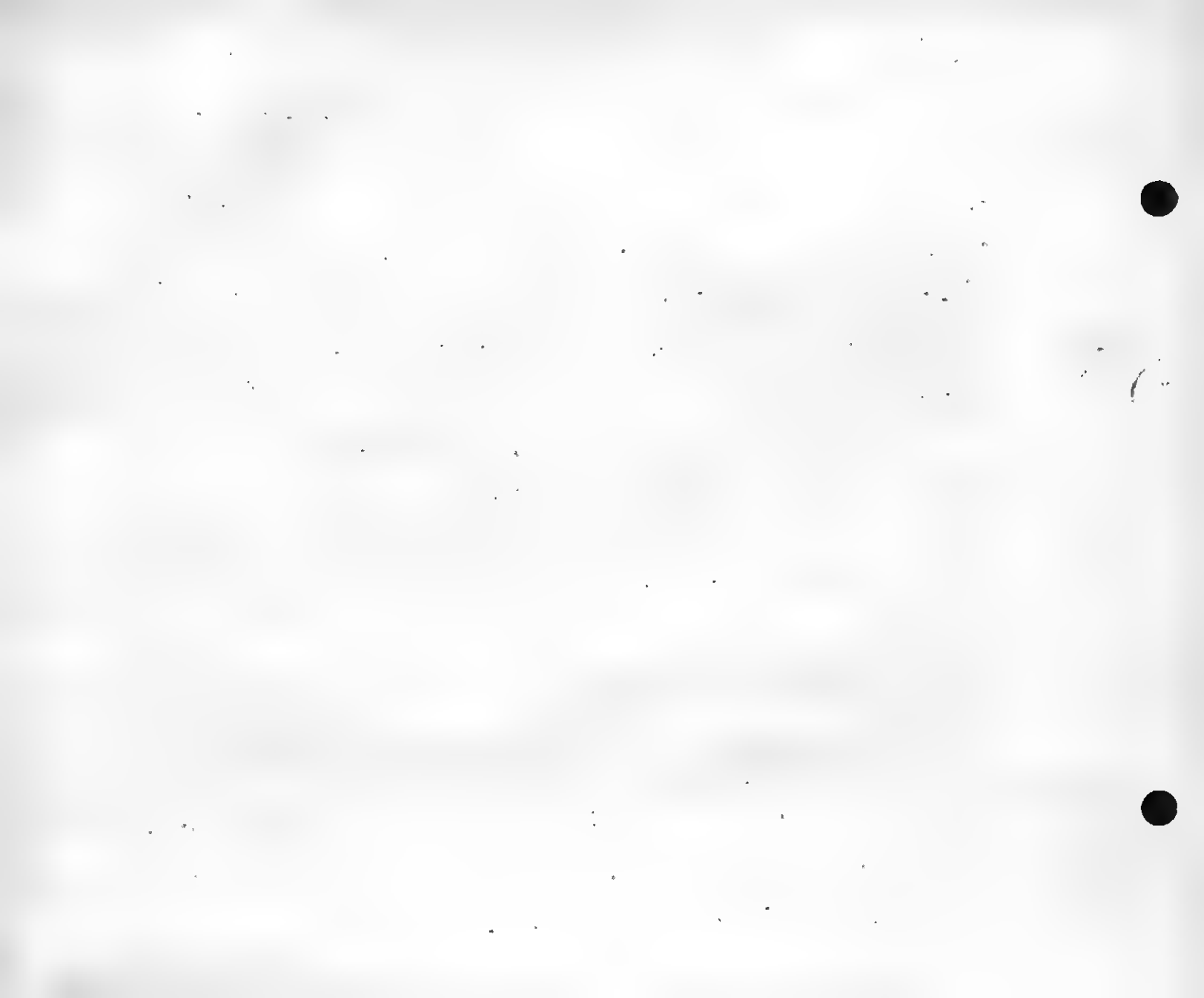
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
12533		12513															
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR								
Eugenia			L			Custer			September 28, 1968			9:20 a.m.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
Female			White			August 8, 1923			15 4/7 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Pennsylvania			U.S.A.						Baltimore 21204			Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
Towson			St. Joseph Hospital			HOUSE WIFE											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address on) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Baltimore			Kingsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Cedar Lane #21087					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First Middle Last			First Middle Last														
ALFRED WALLACE			ELIZABETH MILLER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
UNK						RAYMOND CUSTER											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY.																	
IMMEDIATE CAUSE (a) <u>Intestinal obstruction, chronic</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>Abdominal carcinomatosis</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u>Carcinoma of the colon</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
<u>1 38 Familial polypoidosis, multiple</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
			HOUR A.M. Month Day Year P.M. 19														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No City or Town County State								
22a. I certify that (this hospital) attended the deceased from <u>July 31, 1968</u> , to <u>Sept. 28, 1968</u> , that (I) <u>did</u> saw the deceased alive on <u>Sept. 28, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.																	
22b. SIGNATURE			22c. DATE SIGNED														
Arturo A. Pidlacan MD			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			Sept. 28, 1968								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS														
Arturo Pidlacan, M. D.			7620 York Road, Towson 4, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
BURIAL			10/1/68			GRAVVIEW			JOHNSTON PA.								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
J.G. CONNELLY SONS			300 MACE			DATE OCT 1 1968			Charles Judge								

MEDICAL CERTIFICATION



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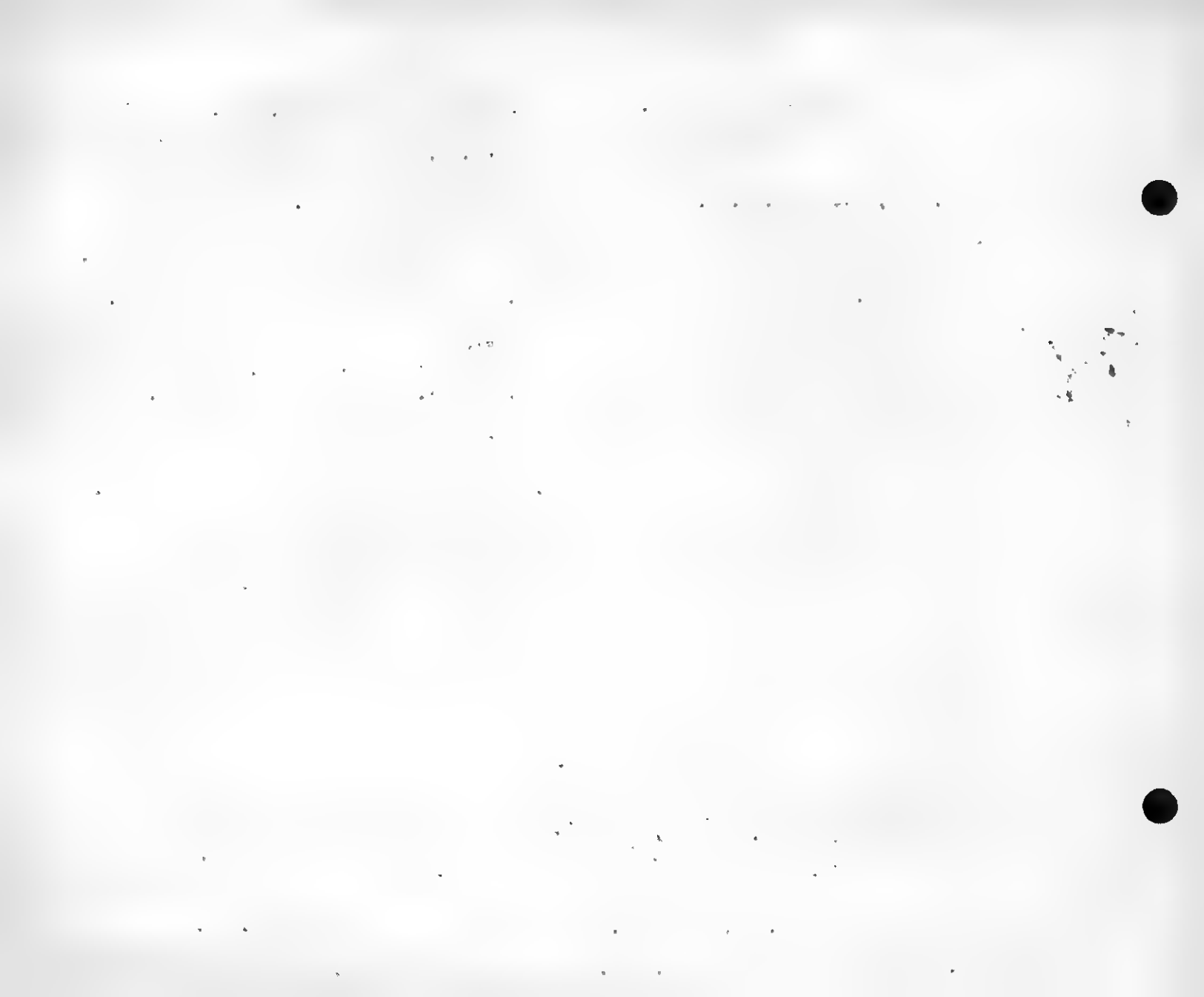
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12534 CERTIFICATE OF DEATH 12514									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary (Sister Benigna) DANNER						9 Month 3 Day 68 Year			9:55 P.M.
3 SEX	4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	Cau		12-8-1880			87 YRS.			
7a BIRTH-PLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Penn.	U. S. A.				Baltimore Md				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore Towson		Greater Balto. Med. Center		Teacher			Education		
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Baltimore		Glen Arm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Glen Arm, Rd.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Danner			Theresa Hartman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No			218-54-2972		Le M. Kathleen		Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis with									
011.7 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pleural effusion									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/21, 19 68, to 9/3, 19 68, that (I) (we) last saw the deceased alive on 9/3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			Charles C. Brown, M.D. DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/4/68	
22d. PHYSICIAN'S NAME (Type)			Charles C. Brown, M.D.			22e. ADDRESS 6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		SEPT 7 68		SISTERS CEMETERY		GLEN ARM MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
RAYMOND D. CURRAN		517 SEAFIELD ST. BALTIMORE MD 21201		SEP 9 1968		J. Charles Judge			

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VR A 15-14
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 13 Film 6405 11/2/68 JGK											
12535			12545								
1. DECEASED NAME (Type or print) Charles			First W. Middle Dayhoff Last			2a. DATE OF DEATH Month Sept. Day 14 Year 1968			2b. HOUR M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH Feb. 7, 1880			6. AGE (In years last birthday) 88 YRS		
7a. BIRTHPLACE (State or foreign country) Mt. Airy, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balto.		
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Gas Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Unknown Middle Unknown Last Unknown			15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		
17. INFORMANT Randallstown, Md. Address 21133 Mr. Allan W. Dayhoff 3731 Offuth Rd.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4127 Atherosclerosis C.V.D. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis Coronary DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinsonism											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1967 to Sept 14, 1968 , that (I) (we) last saw the deceased alive on Sept 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Nelson McKay M.D.			22c. DATE SIGNED 9/17/68			22d. PHYSICIAN'S NAME (Type) J. NELSON MCKAY, M.D.			22e. ADDRESS 6014 EDMONDSON AVE Balto Md 28		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 18, 1968			23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.			23d. LOCATION (City or Town) (County) (State) Howard Co. Md.		
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. Nat. Pike 21229			25a. REC'D BY REGISTRAR SEP 18 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge					



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12536

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 13 & 17 of the 1968 k

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Charles R. Delbrook, Sr.			2a. DATE OF DEATH Month 9 Day 2 Year 68 8:26 ^{PM}		
3 SEX Male	4. RACE White	5 DATE OF BIRTH Oct. 26, 1906		6 AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sept 68	9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GUARD	12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Baltimore	13c INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET AND NUMBER 1222 Washington Blvd. 8520 Harris Ave. 21213		
14. FATHER'S NAME First Middle Last JOHN DELBROOK			15 MOTHER'S MAIDEN NAME First Middle Last CINDERELLA SATOFF		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, up to (Unknown) (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 212 03 9804	17 INFORMANT Delbrook Address Mildred Delbrook 1222 Washington Blvd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal bleeding. 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Portal cirrhosis. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION 9-1-1968		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Gastro-intestinal bleeding		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1 , 19 68 , to Sept. 2 , 19 68 , that (I) (we) last saw the deceased alive on Sept. 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE William			DEGREE Attending	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c DATE SIGNED 9-2-1968
22d. PHYSICIAN'S NAME (Type) Ines Ciliani, M.D.			22e. ADDRESS		
23a BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b DATE 9/6/68	23c NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City or Town) (County) (State) Glen Burnie MD	
24. FUNERAL DIRECTOR McCully		ADDRESS 130 E. Fort Ave Baltimore		25a. REC'D BY REGISTRAR SEP 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



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1

12537

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12517

1. DECEASED-NAME (Type or print) WILLIAM DEVILBISS			2a. DATE OF DEATH Month 9 / Day 5 / Year 1968			2b. HOUR 11 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH 8/28/1887		6. AGE (in years last birthday) 81 YRS	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Mt. Wilson State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Carroll.		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First William Middle Devilbiss Last Devilbiss		15. MOTHER'S MAIDEN NAME First ELIZABETH Middle WARD Last WARD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 212-03-9626		17. INFORMANT Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/20/1968 to 9/5/1968 , that (I) (we) last saw the deceased alive on 9/5/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Newcomer		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/5/68	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/7/68		23c. NAME OF CEMETERY OR CREMATORY CARROLLTON CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) FINKSBURG RD, MD.	
24. FUNERAL DIRECTOR S. E. Myers Jr.		ADDRESS Westminster, Md.		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 422a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH
10-30-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12548

12538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) JASPER DICKENS						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 9 Day 8 Year 1968		2b. HOUR 11:35 AM	
3. SEX male	4. RACE Negro	5. DATE OF BIRTH 10-12-24	6. AGE (in years last birthday) 43 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD September 8, Year 1968		2d. HOUR 11:35 AM	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Medical Cntr				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 735 E. Biddle St.	
14. FATHER'S NAME First Eliza Middle Dickens Last Dickens				15. MOTHER'S MAIDEN NAME First Larry Middle Dickens Last Dickens				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Larry Dickens 1225 Gay St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. 4109 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420,									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 1348 Calhoun St.		City or Town Rocky Mt.		County North Carolina State North Carolina	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 9/10/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-15-68		23c. NAME OF CEMETERY OR CREMATORY Church Cem.		23d. LOCATION (City or Town) (County) (State) Rocky Mt. North Carolina			
24. FUNERAL DIRECTOR James P. Bailey				ADDRESS 1348 Calhoun St.		25a. REC'D BY REGISTRAR SEP 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12539 Item 6 Film 640-5715706-22									
12549									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.
Raymond			Donaldson			Sept. 1, 1968			12:30
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male		white		12/1/1895		83 72 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Md.		U.S.				Baltimore			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			SPRING GROVE STATE HOSP.						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Pr. Geo.		Beaver Hts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		none
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Zachariah Donaldson			Laura Higgins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
(If yes give war or dates of service)			219-54-3094		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic bronchitis and</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S.C.V.D. (arteriosclerosis)</i> 4129 (Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>300 mgn Digoxin Hyponatremia (lost. hypokalemia UT)</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE, BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that <i>he</i> (this hospital) attended the deceased from <i>April 30, 1936</i> to <i>Sept. 1, 1968</i> , that <i>he</i> (we) last saw the deceased alive on <i>April 30, 1936</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Rafael H. Marin</i>			DEGREE Rafael H. Marin, M. D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>9/2/68</i>		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>9/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Johns Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Ellicott City Balt. Md.</i>		
24. FUNERAL DIRECTOR <i>E. B. Mac Nabb</i>			ADDRESS <i>301 Frederick Rd Balt 28 Md</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR					
Harry E. J. Dorsey, Sr.						Sept. 21, 1968			M					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		7 IF UNDER 24 HRS			
male		white		Aug. 21, 1904			64 YRS		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Baltimore			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Parkville			3019 Willoughby Rd.			Marti. Superintendent G. Motors								
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Md.			Baltimore			Parkville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3019 Willoughby Road		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last											
Milton Dorsey			Margaret B. Dorsey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO. (If yes give year or dates of service)			17 INFORMANT Address								
			213104495			Marie A. Dorsey			same					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous.</u>														
154.1 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Rectum</u>												2 year		
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
104.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-68</u> , 19 <u>68</u> , to <u>Sept 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <u>Harold H. Burns</u>			22c DEGREE <u>MD</u>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22e DATE SIGNED <u>9-23-1968</u>					
22d. PHYSICIAN'S NAME (Type)			22a ADDRESS											
Harold H. Burns MD			8106 Harford Rd. Balt. Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			9-25-68			Parkwood Cemetery			Baltimore, Md.					
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc Baltimore, Md.						SEP 24 1968			<u>[Signature]</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12541											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month		Day	Year		
HELEN				BARRICK	DRURY	9		21	68		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
FEMALE		White		Aug. 14, 1896		72 YRS.		MONTHS DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE, MD.			Greater Balto. Med. Cen.			Schoolteacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3133 Rosalie Ave		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
James			P		Drury	Mary					Thomas
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			214-40-5235			Mr James P Drury			2814 Bauernwood Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA											
174X DUE TO, OR AS A CONSEQUENCE OF (b) TO LUNG AND PLEURA											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
170X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from 8/26, 1968, to 9/21, 1968, that (I) (we) last saw the deceased alive on 9/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Charles C. Brown						9/21/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
CHARLES C. BROWN MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9/25/68		Parkwood		Baltimore,		Maryland			
24. FUNERAL DIRECTOR						ADDRESS		25. REC'D BY REGISTRY		DATE	
Leonard J Ruck Inc						Baltimore, Md		SEP 24 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12542

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12552

1. DECEASED-NAME (Type or print) REV. Hugh		First J.		Middle Duffy SSJ		Last Duffy SSJ		2a. DATE OF DEATH Month Day Year September 18, 1968		2b. HOUR 11 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH January 28, 1901		6. AGE (In years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,				Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Religious CATHOLIC PRIEST		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7620 York Rd.			
14. FATHER'S NAME JAMES		First DUFFY		Last BRIDGET		15. MOTHER'S MAIDEN NAME First MC CAUL		Middle MC CAUL		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT REV. G.F.O'DEA SSJ 1130 N. CALVERT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure sec. to myocardial DUE TO, OR AS A CONSEQUENCE OF infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/31 , 19 68 , to 9/18 , 19 68 , that (I) (we) lost saw the deceased alive on 9/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.											
22b. SIGNATURE Christina Feliciano, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/19/68					
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/21/68		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.					
24. FUNERAL DIRECTOR H.W. NEARS & SON 805 N. CALVERT ST		ADDRESS		25a. REC'D BY REGISTRAR SEP 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12543		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12543									
Item 23b, File GL 25 10/7/68 km		CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR					
RAYMOND		F.		DURBIN				Month 9 Day 17 Year 68		11:10 PM					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS					
MALE		WHITE		4/25/08		80 YRS.		MONTHS		DAYS					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
BALTIMORE, MARYLAND		U.S.A.				BALTIMORE COUNTY,									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
FORT HOWARD		VET. ADM. HOSPITAL		LABORER		BOAT YARD									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIM 157		13e. STREET AND NUMBER									
MARYLAND		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT 15, BOX 2, BOWLEY'S CTRS ROAD									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
JOSEPH		DURBIN						BERTHA		FRANCIS					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address									
YES		PL 28		218 01 35 72		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.									
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY INFARCTION								RECENT					
		1621 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOPNEUMONIA								RECENT					
		Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CARCINOMA, LEFT LUNG,								OLD					
MEDICAL CERTIFICATION		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
		METASTATIC CARCINOMA LYMPH NODES, LIVER AND KIDNEYS													
		19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES					
MEDICAL CERTIFICATION		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				HOUR A.M. Month Day Year											
				P.M. 19											
MEDICAL CERTIFICATION		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No		City or Town		County		State	
MEDICAL CERTIFICATION		22a. I certify that (X) (this hospital) attended the deceased from 8/29/68, 19, to 9/17/68, 19, that (H) (we) last saw the deceased alive on 9/17/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (and) (did not) view the body after death.													
		22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED					
										9/17/68					
		22d PHYSICIAN'S NAME (Type)		KRISHNA V. S. RAO, M. D.		22e ADDRESS		VAH FORT HOWARD, MARYLAND							
MEDICAL CERTIFICATION		23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)			
		BURIAL		9/21/68		ALL SAINTS CEMETERY I		REISTERSTOWN, MD.							
MEDICAL CERTIFICATION		24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTER'S SIGNATURE							
				ZANNINO FUNERAL HOME		SEP 19 1968		Charles Judge							
				257 S. CONKLING ST. BALTIMORE, MD.											



12544

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR		
JAMES					DWYER, JR.	SEPTEMBER 17, 1968			11:00 P		
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		SEPTEMBER 24, 1889		78 YRS.		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
LONDON, ENGLAND		USA				BALTIMORE		Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
TOWSON		ST. JOSEPH, HOSPITAL		Ware Cutter Retired		Steel					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
STATE MARYLAND		BALTIMORE		Overlea				5007 KENWOOD AVE. #21206			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
James					Dwyer	Margaret					Fitzgerald
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT		Address					
No		213-07-4205		Eugene Jendricks		4507 Fullerton Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral.</u>											
150X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>Starvation secondary to recurrent</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>esophageal carcinoma.</u>											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1777X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)			21f LOCATION		Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 15, 1968</u> , to <u>SEPT. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 17, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED				
<i>Christiana Feliciano, M.D.</i>							Sept. 18, 1968				
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS						
Christiana Feliciano, M.D.					7620 York Rd., Towson, Md. 21204						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)		
Burial		Sept 20 1968		Holy Redeemer Cemetery		4200 Belair Rd		Baltimore	Md		
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE		
THE DIPPEL BROS INC					7110 BELAIR RD		DATE SEP 20 1968		<i>Charles Judge</i>		

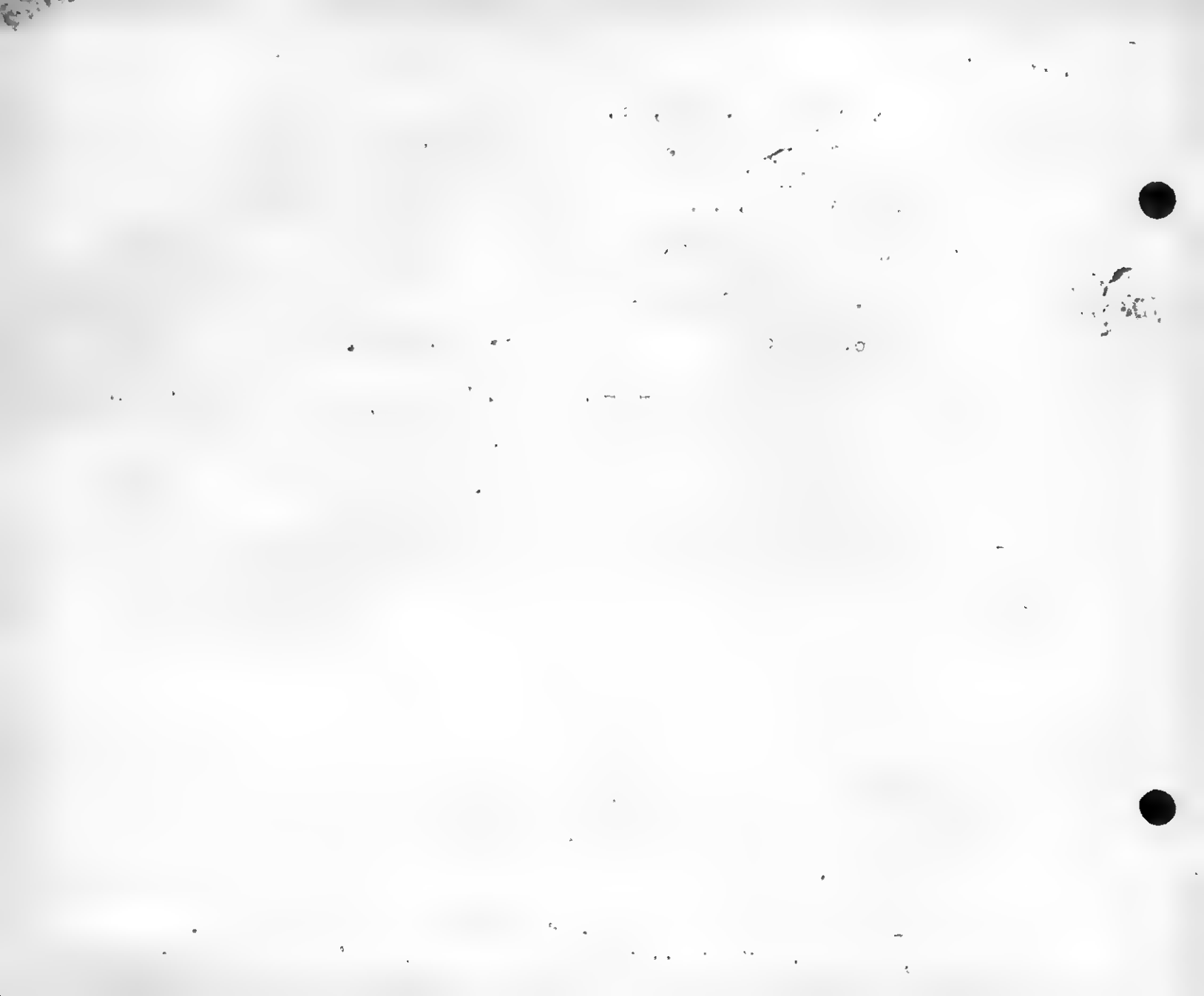
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Charles W. Dyer, Sr.			2a. DATE OF DEATH Sept Month 24 Day 1966 Year			2b. HOUR 4. P. M.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7/18/86		6 AGE (In years last birthday) 82 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Arbutus			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1075 Elm Road			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b CITY OR TOWN Baltimore		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1075 Elm Road, 21227		
14. FATHER'S NAME First Middle Last Thomas Dyer			15. MOTHER'S MAIDEN NAME First Middle Last Emma Eckert						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 216-09-3767		17 INFORMANT Address Mrs. Doris Eichelberger, 1075 Elm Rd., 21227				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4109									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from Sept 24, 1966 , to Sept 24, 1966 , that (I) (we) last saw the deceased alive on Sept 24, 1966 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stanley Ankudas				22c. DATE SIGNED 9/25/68		22d. PHYSICIAN'S NAME (Type) Dr. Stanley Ankudas			
22e. ADDRESS 1101 Maiden Choice Lane									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/27/68		23c. NAME OF CEMETERY OR CREMATORY Louder Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				25a. REC'D BY REGISTRAR SEP 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



CERTIFICATE OF DEATH

12546

12546

1. DECEASED-NAME (Type or print) Mary			First -			Middle -			Last EASTER			2a. DATE OF DEATH Month 9 Day 27 Year 68			2b. HOUR 5:50 PM											
3. SEX Female			4 RACE Negro			5. DATE OF BIRTH 8/14/56			6 AGE (In years last birthday) 12 YRS			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS HOURS 0 MIN 0											
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore																	
10 CITY OR TOWN OF DEATH Owings Mills			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent			12b. KIND OF BUSINESS OR INDUSTRY None																	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1714 West Fayette Street														
14 FATHER'S NAME First Lonnie Middle - Last Terry			15 MOTHER'S MAIDEN NAME First Lucy Middle - Last Easter																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) none			17 INFORMANT Rosewood Records, Owings Mills, Maryland																				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to placental obstruction terminal DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Birth of Chronic Bronchitis bilateral Severe 2 wks DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Isolation 10 yrs Severe Mental Retardation + Microcephaly															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 58 , to 9/27 , 19 68 , that (I) (we) lost saw the deceased alive on 9/27 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																										
22b. SIGNATURE Richard A. Jones			22c. DATE SIGNED 9/30/68			22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.			22e. ADDRESS Rosewood St. Hospl, Owings Mills, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/3/68			23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetry			23d. LOCATION (City or Town) (County) (State) Baltimore md																	
24 FUNERAL DIRECTOR Adolphus Halstead			25a. REC. BY REGISTRAR OCT 7 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12547

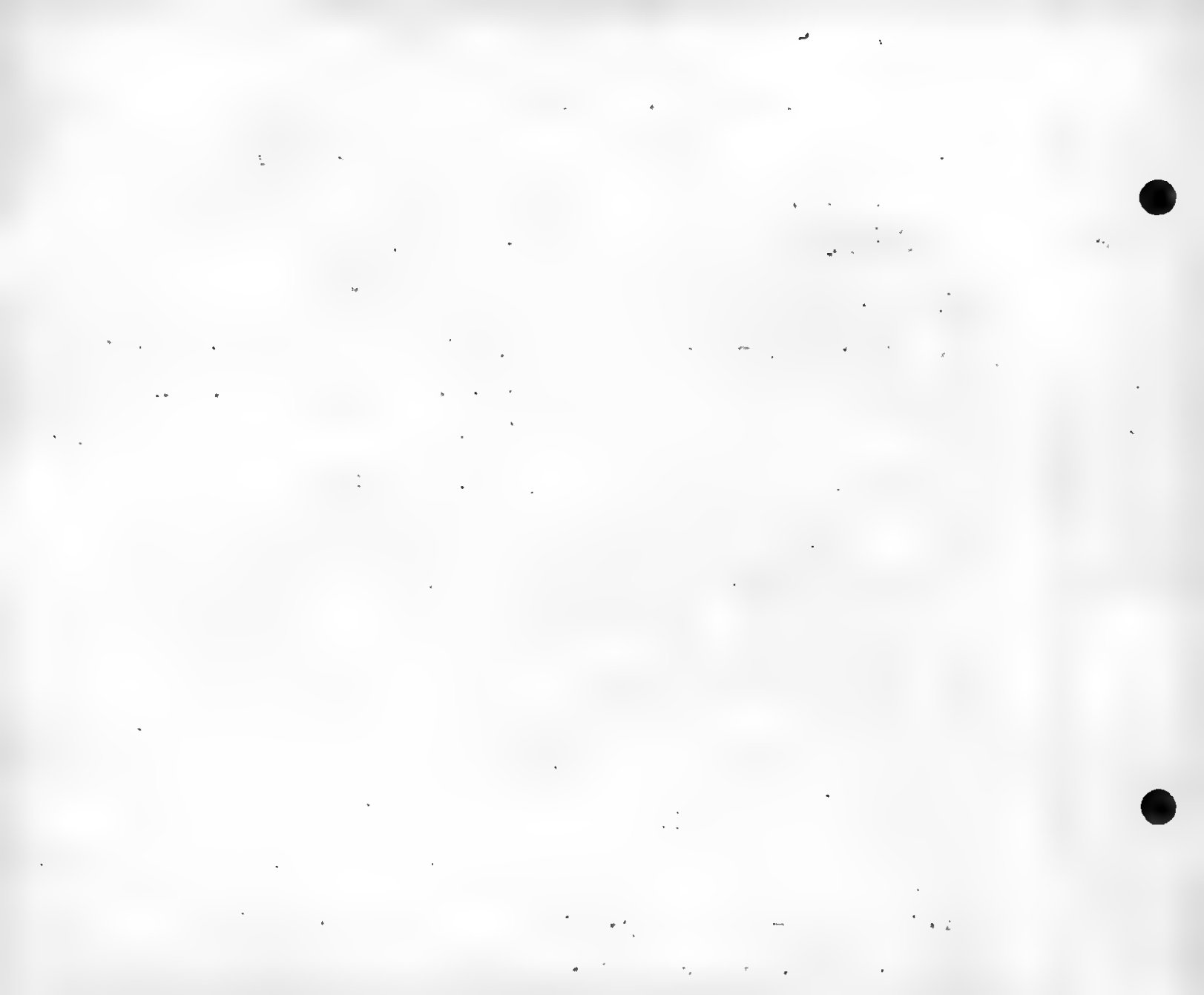
CERTIFICATE OF DEATH

12557

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH			2b HOUR	
ROBERT A. EASTER					Month	Day	Year	7:25 P.M.	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White		Oct 1 1868		99 YRS		MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Highland, Md.						Baltimore Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonville, Md		Shangri La		Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Highland, Md		Howard		Highland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Robert A. Easter sr.					Mary F. Richardson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
				James M. Easter, Highland, Md.		20777			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis									1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 = X									
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis									chronic
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Chronic Bursal disease, mild									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1968, to 9/2, 1968, that (I) (we) last saw the deceased alive on 9/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		9/1	
						812 MOCKINGBIRD LAKE BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		9-5-1968		St. Marks		Highland, Md			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John R. Slack				1111 North-Slack Funeral Home, Ellicott City, Md		DATE SEP 9 1968		John R. Slack	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

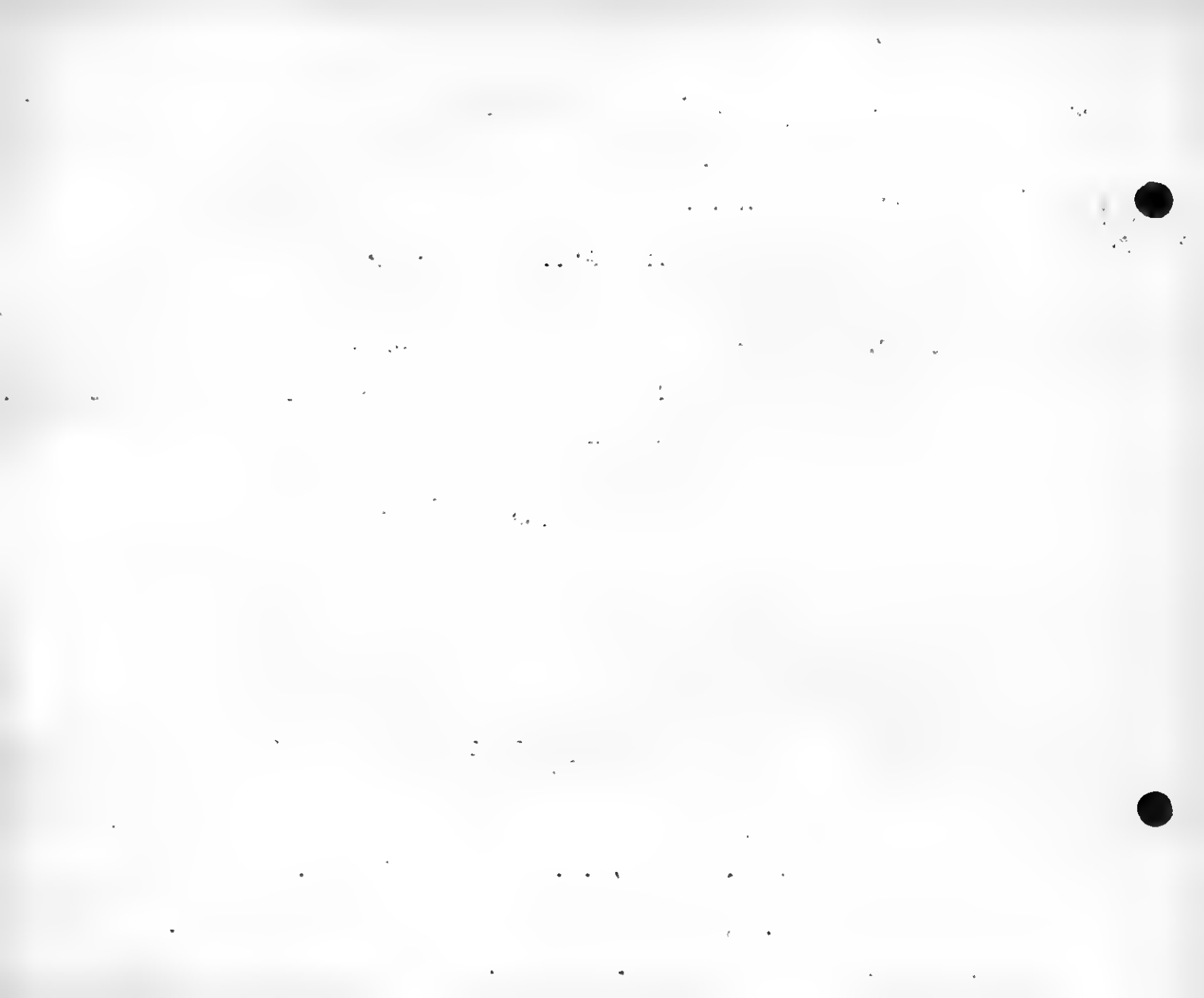
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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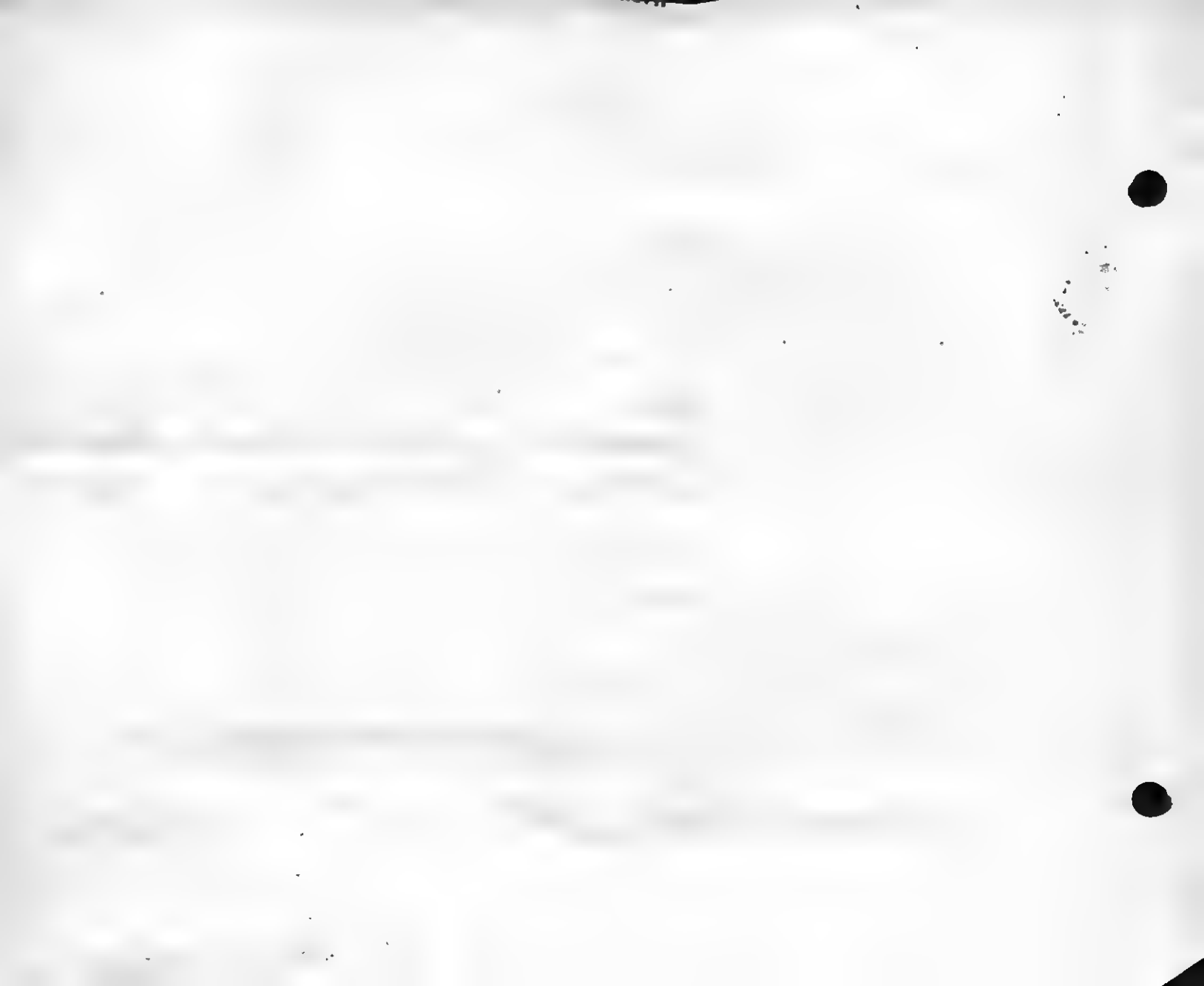
12548										DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12558																																							
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
MAUDE EDNA ECCLESTON										Month 9 Day 3 Year 68										1:58																																							
3 SEX FEMALE										4 RACE CAUCASIAN										5. DATE OF BIRTH 2/10/81										6. AGE (In years last birthday) 87 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH BALTIMORE										Md																			
10. CITY OR TOWN OF DEATH Towson										11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) GREATER BALT. MED. CENTER										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Baltimore										13c CITY OR TOWN Baltimore										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 1904 East 31st Street																			
14 FATHER'S NAME First Middle Last John A. Eccleston										15. MOTHER'S MAIDEN NAME First Middle Last Clara Kepler										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b SOCIAL SECURITY NO. 212-01-1786										17 INFORMANT Miss Alcock, Pickersgill, 615 Chestnut Av.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS																																																											
5641										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) DIVERTICULITIS WITH PERFORATION AND ABSCESS FORMATION																																																	
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										5721																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (X) (this hospital) attended the deceased from 7-15, 1968, to 9-3, 1968, that (X) (we) last saw the deceased alive on 9-3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE Charles C. Brown, M.D.										DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c DATE SIGNED 9-3-68																																							
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN, M.D.										22e. ADDRESS 6701 N. CHARLES ST																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE Sept. 6, 1968										23c. NAME OF CEMETERY OR CREMATORY Loudon Park										23d. LOCATION (City or Town) Baltimore, Md. (County) (State)																													
24. FUNERAL DIRECTOR										ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.										25a REC'D BY REGISTRAR SEP 9 1968										25b REGISTRAR'S SIGNATURE Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) First Middle Last Frances G. Edmonds						2a DATE OF DEATH Month Day Year September 24 1968			2b HOUR 12:30 P.M.			
3. SEX Female		4 RACE White		5. DATE OF BIRTH April 26, 1904			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armcast Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Wiltondale		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 614 Hastings Rd.			
14 FATHER'S NAME First Middle Last Mr. William H.J. Walter						15 MOTHER'S MAIDEN NAME First Middle Last Olga Jahn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16b SOCIAL SECURITY NO.		17 INFORMANT Address Dr. Charles W. Edmonds- Same						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Sudden												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> 1 year												
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 22 / x												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from June 1968, to September 24, 1968, that (I) (we) saw the deceased alive on September 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Charles F. O'Donnell						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 9/24/68			
22d. PHYSICIAN'S NAME (Type) Charles F. O'Donnell						22e ADDRESS 7601 York Rd., Balto. Md. 21204						
23a BURIAL, CREMATION, REMOVAL (Specify) Entombment			23b DATE 9/28/68			23c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.			23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214						25a REC'D BY REGISTRAR SEP 26 1968			25b REGISTRAR'S SIGNATURE Charles J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1515
30M REV.

MARTYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
12550		12560							
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
TALBOT			NMI	EKAS	SEPTEMBER 18 1968			12:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR	
MALE		WHITE		12-15-00		67 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		USA				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown			Balto. County Gen Hosp			Retired Mail Carrier US Gov't			
13a. USAL RESIDENCE (Where deceased lived, if institution residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md			Balto		Woodlawn		2000 Hutton Pl.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Frederick Ekas						Mary L. McGoffin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
NO			216.44.3398		Chart and Family		Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 6 weeks									
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/15, 1968, to 9/18, 1968, that (I) (we) last saw the deceased alive on 9/18/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Fausto Q. Aquino JR					22c. DATE SIGNED 9/18/68				
22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO JR					22e. ADDRESS BALTO. COUNTY GEN. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/20/68		Lorraine Park		Woodlawn Balto. Md.			
24. FUNERAL DIRECTOR J. T. Stansbury 6411 Windsor Mill Rd.					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					SEP 20 1968		Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

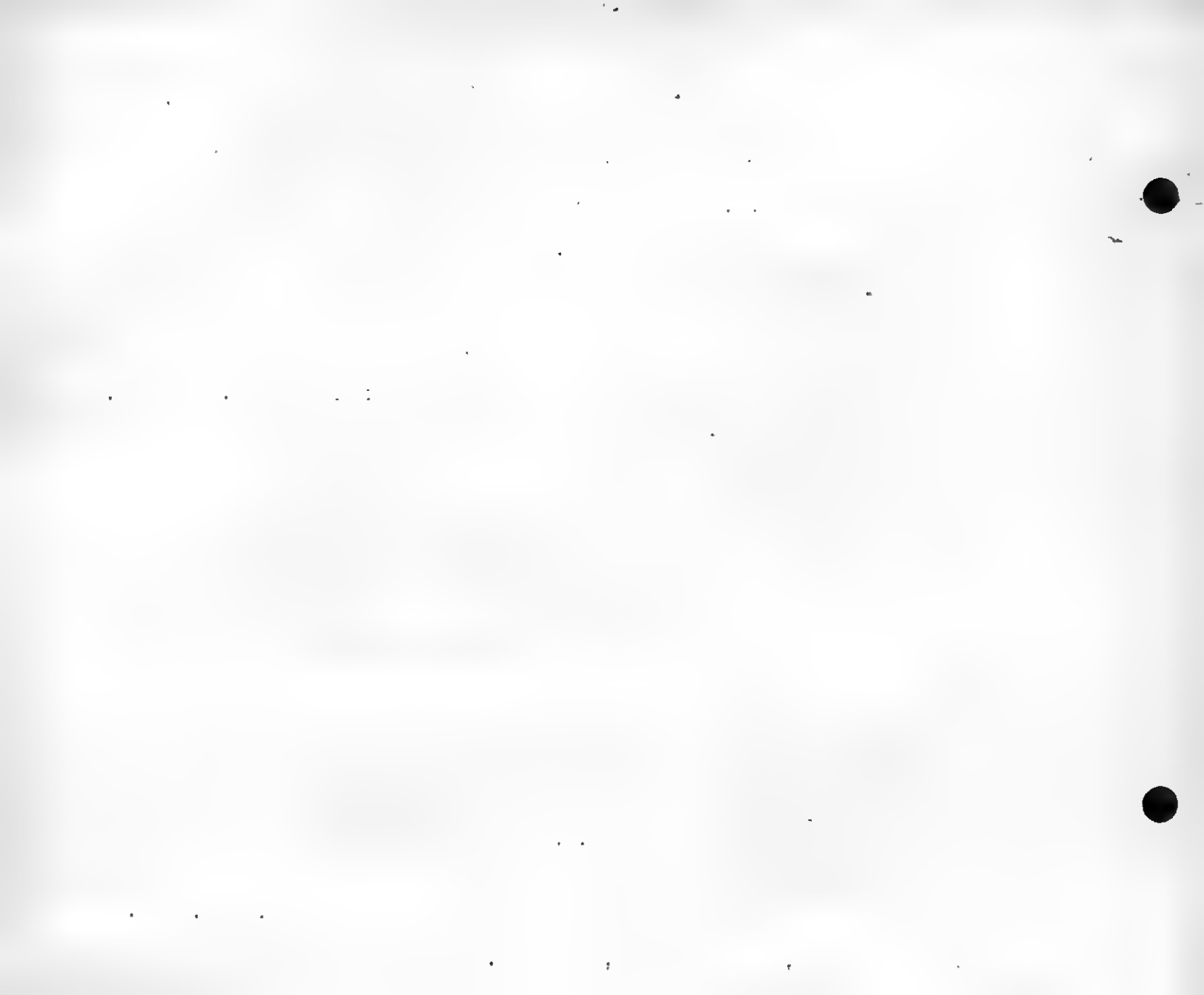
12551

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12561

1 DECEASED-NAME (Type or Print) CHARLES First EUGENE Middle ELRONE Last ELRONE		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Sept. 7, 1968		2b HOUR 3:45 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH March 16, 1918	6 AGE (in years last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) So. Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore
10 CITY OR TOWN OF DEATH Essex		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 9412 Old Phila. Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland COUNTY Baltimore		13b CITY OR TOWN Baltimore	13c INSIDE CITY, M.D. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 508 Winsdom Avenue
14. FATHER'S NAME First Charles Middle Elrone Last Elrone		15 MOTHER'S MAIDEN NAME First Eugenie Middle Kessel Last Kessel		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 216-03-6301		17 INFORMANT Anna B. Warfield ADDRESS 2929 St. Paul St.
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Taxi				
19a DATE OF OPERATION Sept 7, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month Day, Year 19 HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a I certify that I took charge of the removals described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Ronald N. Kornblum EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED September 7, 1968
23a ADDRESS (Street, city, town, or county)		23b DATE SIGNED SEP 13 1968		
23c BURIAL, CREMATION REMOVAL (Specify) Burial		23d DATE 9/11/68		23e NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.
24 FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. ADDRESS 1217 St. Paul St.		25a REC'D BY REGISTRAR SEP 13 1968		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last Molly B. Engel						2a. DATE OF DEATH 9 Month 21 Day 68 Year			2b. HOUR 2p M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 5/20/04		6 AGE (in years last birthday) 64 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Paris, France		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md.					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1525 Medford Road		
14. FATHER'S NAME First Middle Last Bernard Brown				15. MOTHER'S MAIDEN NAME First Middle Last Blanche Braun Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Husband Address McHenry C. Engel, Sr. 1525 Medford Road Baltimore, Maryland 21218						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio-respiratory Failure 1581 DUE TO, OR AS A CONSEQUENCE OF (b) Brain Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1212											
19a. DATE OF OPERATION 8/26/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor of Brain				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 8/5/68 , 19 68 , to 9/21 , 19 68 , that (X) (we) last saw the deceased alive on Sept. 21 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Meshkinpour						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/21/68			
22d. PHYSICIAN'S NAME (Type) Dr. Hooshang Meshkinpour M.D.						22e. ADDRESS G.B.M.C. 6701 N. Charles					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster						ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1

12553

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12553

1. DECEASED-NAME (Type or print) First Middle Last ELSIE MARIE ENNIS			2a. DATE OF DEATH Month 9 Day 24 Year 68		2b. HOUR 11:40 AM
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH April 24, 1902	
6. AGE (in years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH BALTO., MD. Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO., MED. CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 124 Westbury Rd.	
14. FATHER'S NAME First Middle Last William Franks			15. MOTHER'S MAIDEN NAME First Middle Last Etta Barnett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17. INFORMANT Address Michael J. Ennis 124 Westbury Rd. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 114x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170x (b) Carcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) GI bleeding - Septicemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur E. Cocco		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 9-23-68		22d. PHYSICIAN'S NAME (Type) Arthur E. Cocco			
22e. ADDRESS 107 E Chase St Balto.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 9/27/68		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. REC'D BY REGISTRAR SEP 27 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12554

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12564

1. DECEASED-NAME (Type or print) LAWRENCE			First Middle Last E. ENSOR			2a. DATE OF DEATH Month 09 Day 23 Year 68			2b. HOUR 12 AM PM		
3. SEX MALE			4. RACE white			5. DATE OF BIRTH Feb. 14, 1898			6. AGE (In years last birthday) 70 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY Md		
10. CITY OR TOWN OF DEATH TOWSON, MARYLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CNTR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) attorney			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN TOWSON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last John B. Ensor			15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Green			13e. STREET AND NUMBER 405 W. PENN. AVE.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give year or dates of service) W.W.W. I			16b. SOCIAL SECURITY NO. 216-38-3021			17. INFORMANT Mrs. Mary G. Ensor			Address 405 W. Penna. Ave. #21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9-25 , 19 68 , to 9-25 , 19 68 , that (I) (we) last saw the deceased alive on 9-25-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm. L. S. Yeh DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED 9/25/68		
22d. PHYSICIAN'S NAME (Type) WILLIAM L.S. YEH			22e. ADDRESS GBMC								
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE 9/27/68			23c. NAME OF CEMETERY OR CREMATORY Mount Maria			23d. LOCATION (City or Town) (County) (State) Towson, Baltimore, Md.		
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			ADDRESS 6500 York Road			25a. REC'D BY REGISTRAR SEP 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12555

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12565

1. DECEASED NAME (Type or print) Madaline		First A.	Middle	Last Evans	2a. DATE OF DEATH Month September Day 20 Year 1968			2b. HOUR M	
3 SEX Female		4. RACE White		5. DATE OF BIRTH November 28, 1914		6. AGE (In years lost birthday) 53 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY Trans- portation	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3436 Yorkway		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookkeeper		13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3436 Yorkway		14. FATHER'S NAME First Hubert Middle Foxwell Last Foxwell		15. MOTHER'S MAIDEN NAME First Ruby Middle Murphy Last Murphy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 215-07-9116		17. INFORMANT (Husband) Elmer E. Evans		Address 3436 Yorkway, Balt. Md. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) carcinoma, pancreas 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hydronephritis, right kidney DUE TO, OR AS A CONSEQUENCE OF (c) obstructive jaundice APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1578									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4.2.55 , 19____, to 9.21.68 , 19____, that (I) (we) last saw the deceased alive on 9.21.68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death									
22b. SIGNATURE Eugene F. Nevy M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9.23.68			
22d. PHYSICIAN'S NAME (Type) Eugene Nevy M.D.		22e. ADDRESS 7001 Mornington Rd. Balt. Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Sept 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Balt. Md. 21222		25a. REC'D BY REGISTRAR SEP 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12556

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12566

1 DECEASED-NAME (Type or print) First Middle Last LEO E. FALLON			2a. DATE OF DEATH Month Day Year SEPT 18 1968			2b. HOUR 9:30PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 2/19/1885		6 AGE (In years lost birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital state street address) JOSEPH'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED FARMER AGRICULTURE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN Glenelg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER WEST FRIENDSHIP, MD.	
14 FATHER'S NAME First Middle Last JOHN - FALLON			15 MOTHER'S MAIDEN NAME First Middle Last HANNAH - ELWOOD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 176-22-0604A		17 INFORMANT Address Mrs Howard Estes West Friendship, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Leukemia with Thrombocytopenia and Anemia DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from SEPT 2 , 19 68 , to SEPT 18 , 19 68 , that (I) (we) last saw the deceased alive on SEPT 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.									
22b. SIGNATURE Camilo L. Tomboc				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/18/68			
22d. PHYSICIAN'S NAME (Type) CAMILO L. TOMBOC, M.D.				22e. ADDRESS 7620 YORK RD. TOWSON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 9-22-68		23c. NAME OF CEMETERY OR CREMATORY SOUTH GIBSON		23d. LOCATION (City or Town) (County) (State) SOUTH GIBSON PENNA			
24. FUNERAL DIRECTOR Harry W. Knight				ADDRESS Silverdale, Md		25a. REC'D BY REGISTRAR DATE SEP 24 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR					
Charles			Fangmeyer			Sept. 25 1968			7457 AM					
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Male		White		June 4, 1893			75 YRS.							
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Maryland			U. S. A.						Baltimore			Md.		
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville, Md.				112 Maiden Choice Lane				Bookkeeper Ret.						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER				
Maryland				Baltimore		Catonsville				112 Maiden Choice Lane				
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last										
Charles Fangmeyer				Lillie Knatz										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17 INFORMANT		Address						
No				212-05-8021		Elsie V. Fangmeyer		112 Maiden Choice Lane						
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))														
PART 1 DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>														
DUE TO, OR AS A CONSEQUENCE OF														
(b) <i>Cardio Vascular Disease & Congestive Failure</i>														
DUE TO, OR AS A CONSEQUENCE OF														
(c) <i>Failure</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
<i>Chronic Emphysema</i>														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>6/11</i> , 19 <i>65</i> , to <i>9/25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <i>Elliott W. Johnson</i> M.D. DEGREE								ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>9/26/68</i>				
22d. PHYSICIAN'S NAME (Type) Elliott Johnson								22e. ADDRESS 3432 Frederick Ave., Balto. Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)						
Burial			9-28-68		Loudon Park Cemetery			Baltimore, City, Md.						
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Avenue 21229						25a REC'D BY REGISTRAR DATE SEP 27 1968		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>						

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

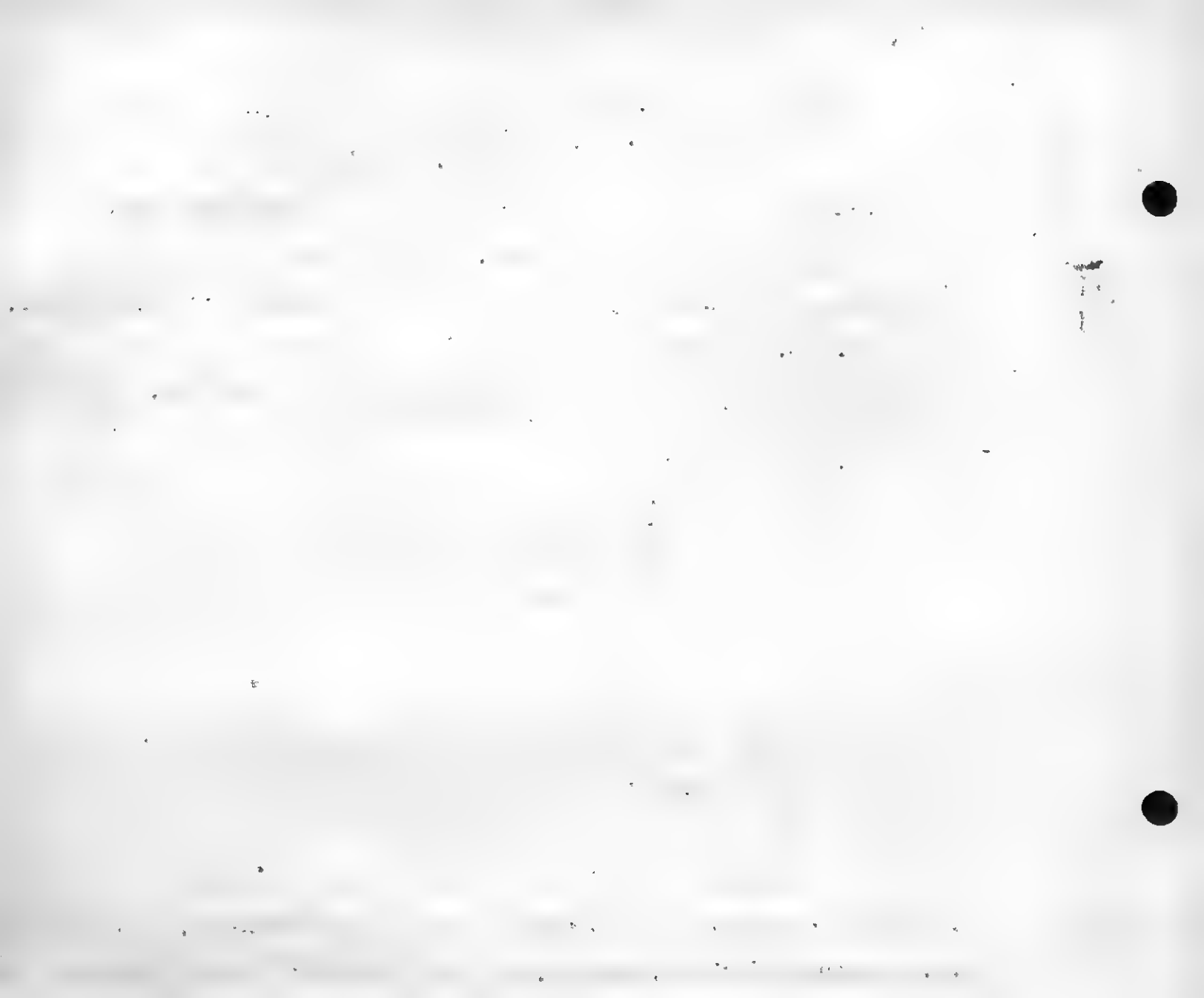
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Philip Copeland			Feffer			Month Day Year			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	8-28-47	21 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		M	
Md.		U.S.A.		WIDOWED		DIVORCED		BALTIMORE		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St Joseph Hosp			Student			College		
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
PA			PRIMA			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			354 W. Schoolhouse Lane		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Phillip Charles Feffer			Jeanne Frances Ruzicka								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
No			212-52-8081			Phyllis Cook			180 Stumm & R. Towson, Md.		
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 827.8 CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) FRACTURE CERVICAL SPINE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
2a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			P.M. 9/4/68			FELL OFF HORSE					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State					
			STREET			COXRD. HARFORD Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.D.			DEPUTY MEDICAL EXAMINER			9-4-68		
William B. Pillsbury						ADDRESS (Street City Town State)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			9-7-1968			Holy Redeemer			Baltimore, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
K. Cock-Brooks-Townson, Inc. 1030 York Rd, Towson, Md. 41264						SEP 6 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12559 Item 13 Film 6067 Harford Rd. 12569											
1 DECEASED-NAME (Type or print)						2a DATE OF DEATH			2b HOUR		
First Middle Last						Month Day Year			M		
Mary E Feick						Sept 6			1968		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS		8 IF UNDER 24 HRS. HOURS MIN.	
F		W		Jan. 2 1879		89 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Baltimore		USA				Baltimore					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Randallstown		Chapel Hill Nur. Home		Housewife							
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md		Howard		Baltimore				3723 N. Garrison Avenue Liberty and Robeson Rd.			
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
John C. Engelmeier				Collins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						Son		3723 Garrison Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
A.S.H.D.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9-4-1968, to 9-7-1968, that (I) (we) lost saw the deceased alive on 9-7-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE Dr. Barbu Calin M.D.				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 9-7-68			
22d. PHYSICIAN'S NAME (Type) Dr BARBU CALIN				22e ADDRESS 215. St Johns Lane E. County							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		Sept 9 68		Moreland		Balto Co.					
24 FUNERAL DIRECTOR P.A. Heemann				ADDRESS 6067 Harford Rd.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
						DATE SEP 10 1968					

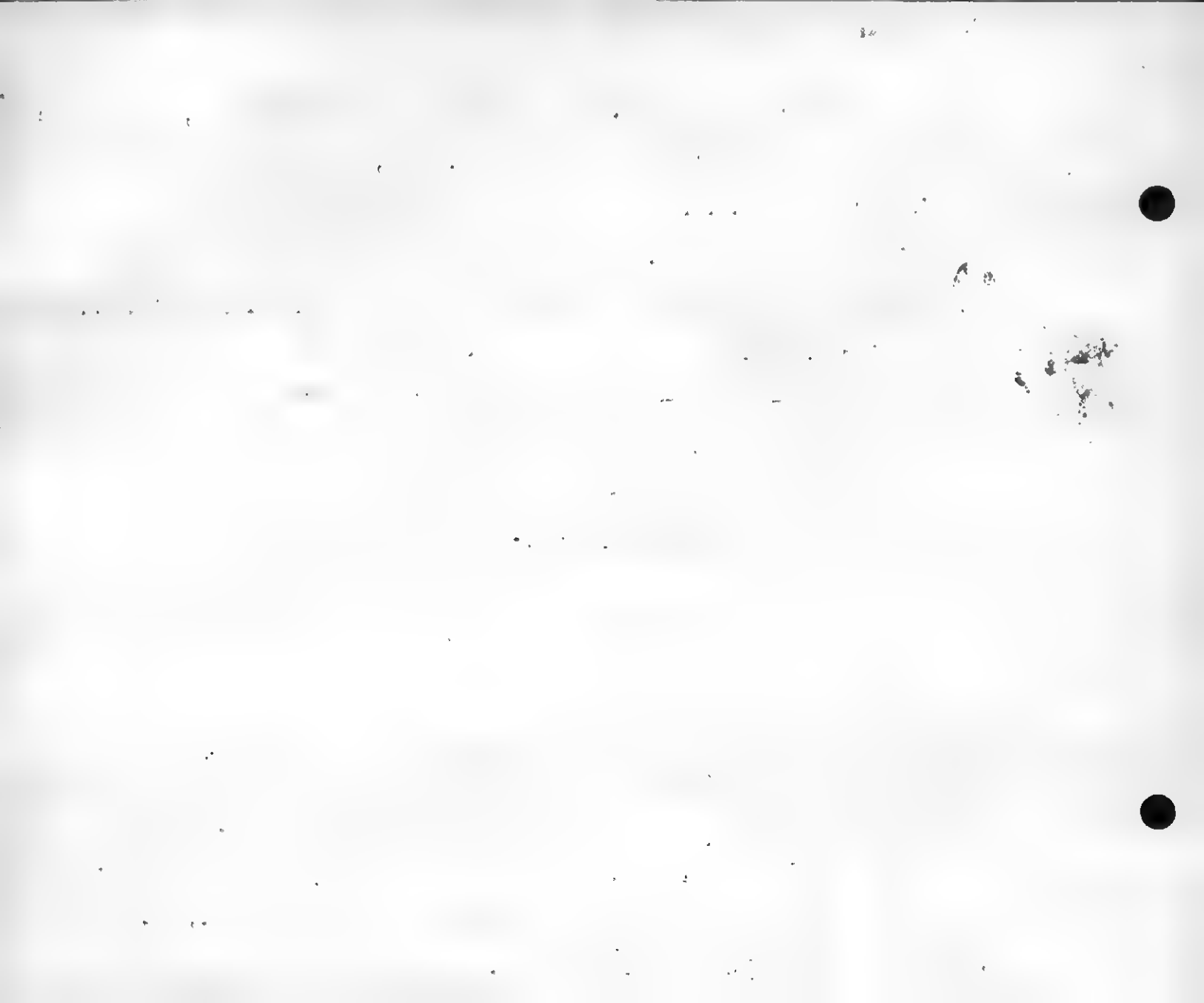


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VR A 15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR	
MILDRED		L.		FERRARE		SEPTEMBER 25, 1968			12:30			
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
FEMALE		WHITE		MARCH 9, 1913			55 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		U.S.A.				BALTIMORE						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON			ST. JOSEPH HOSPITAL			HOMEMAKER			USA			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND			BALTIMORE		Essex				462 1/2 BARRISON PT. RD. 21221			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Harris Buehler										Catherine Henry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT						
No				None		Joseph Ferrare Same						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive acute myocardial infarction with</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial rupture</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>September 18, 68</u> to <u>September 25, 68</u> , that (I) (we) lost saw the deceased alive on <u>September 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>William</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/25/68				
22d. PHYSICIAN'S NAME (Type) Ines Chilliani, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			9/28/68		Oak Lawn Cemetery			Baltimore Co., Md.				
24. FUNERAL DIRECTOR <u>Bruzdinski Funeral Home</u>						ADDRESS 1407 Eastern Ave.		25a. REC'D BY REGISTRAR SEP 27 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

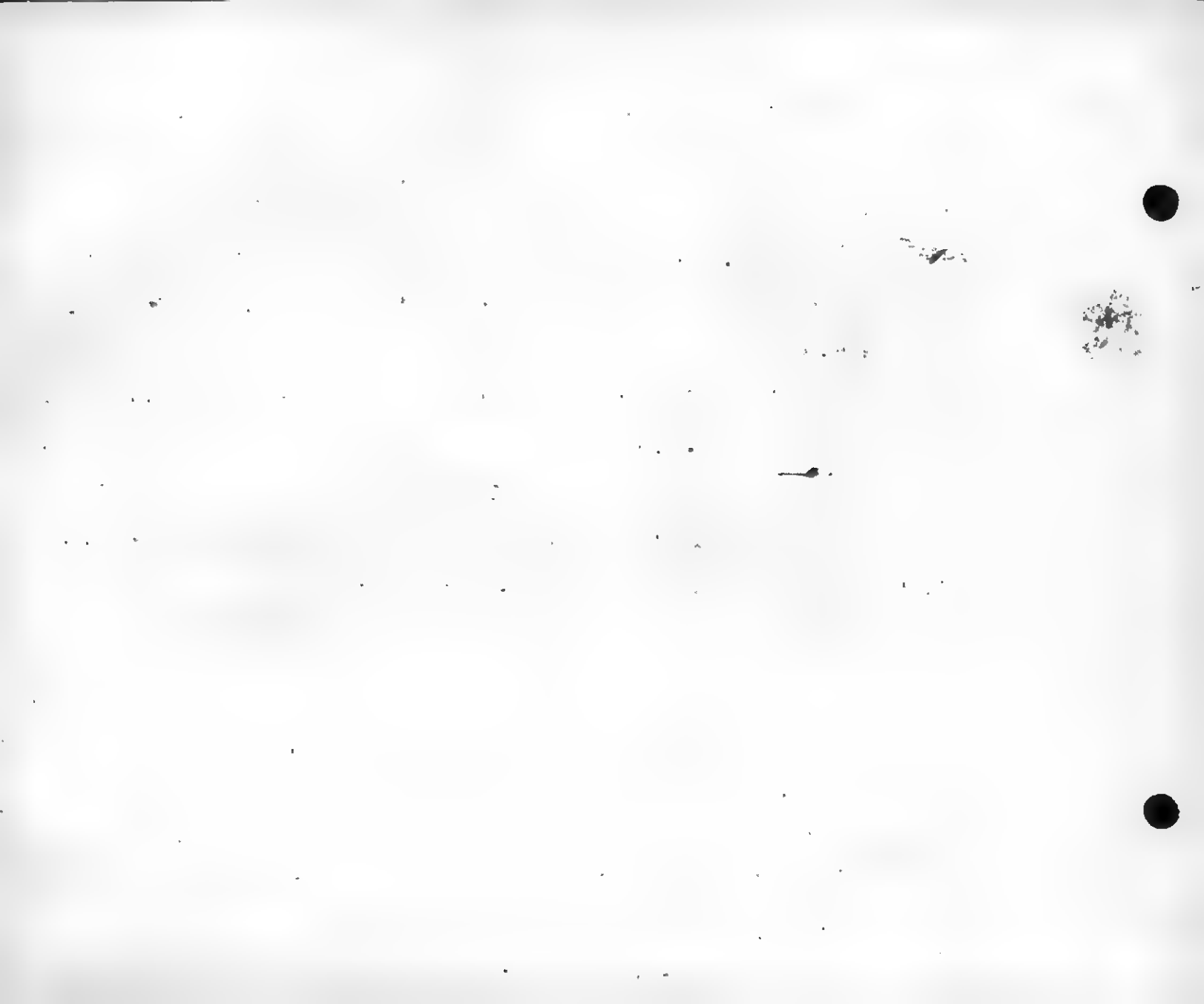


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MEDICAL CERTIFICATION

12561												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												12571																	
Item #6, Film GL05 10/2/68 km												CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)						First WALTER						Middle G.						Last FINK						2a. DATE OF DEATH				2b. HOUR													
																		Month 9						Day 19				Year 68				11:30 PM									
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH 7/31/19				6. AGE (In years lost birthday) 59 YRS				IF UNDER 1 YEAR MONTHS				IF UNDER 24 HRS DAYS				IF UNDER 24 HRS HOURS				IF UNDER 24 HRS MIN													
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore County, Md																													
10. CITY OR TOWN OF DEATH FORT HOWARD						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL						12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) FURNACE INSTALLER						12b. KIND OF BUSINESS OR INDUSTRY HEATING																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND						13b. COUNTY BALTIMORE						13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 610 S. LUZERNE AVENUE																					
14. FATHER'S NAME						First WALTER						Middle FINK						Last MARY						15. MOTHER'S MAIDEN NAME						First NEVILLE						Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES						16b. SOCIAL SECURITY NO. WN 11						17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.						Address																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART DEATH WAS CAUSED BY.																		RECENT & OLD																							
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA																																									
DUE TO, OR AS A CONSEQUENCE OF																		OLD																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																									
(b) BRONCHOGENIC CARCINOMA																																									
DUE TO, OR AS A CONSEQUENCE OF																																									
(c) METASTATIC CARCINOMA, LYMPH NODES, LIVER, SPLEEN & LUNG.																																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PLEURAL EFFUSION, BIL. RECENT. PULMONARY HEARTDISEASE, OLD																																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)						21f. LOCATION Street or RFD No City or Town County State																													
22a. I certify that (X) (this hospital) attended the deceased from 8/29/68, 19, to 9/19/68, 19, that (X) (we) lost saw the deceased alive on 9/19/68 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																																									
22b. SIGNATURE <i>Peter V. Juvan</i>																		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 9/20/68																	
22d. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.																		22e. ADDRESS VAH FORT HOWARD, MARYLAND																							
23a. B. RIAL, CREMAT ON, REMOVAL (Specify) BURIAL						23b. DATE 9/23/68						23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL						23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND																							
24. FUNERAL DIRECTOR KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTIMORE, MD.																		25a. RECD BY REGISTRAR SEP 23 1968						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																	

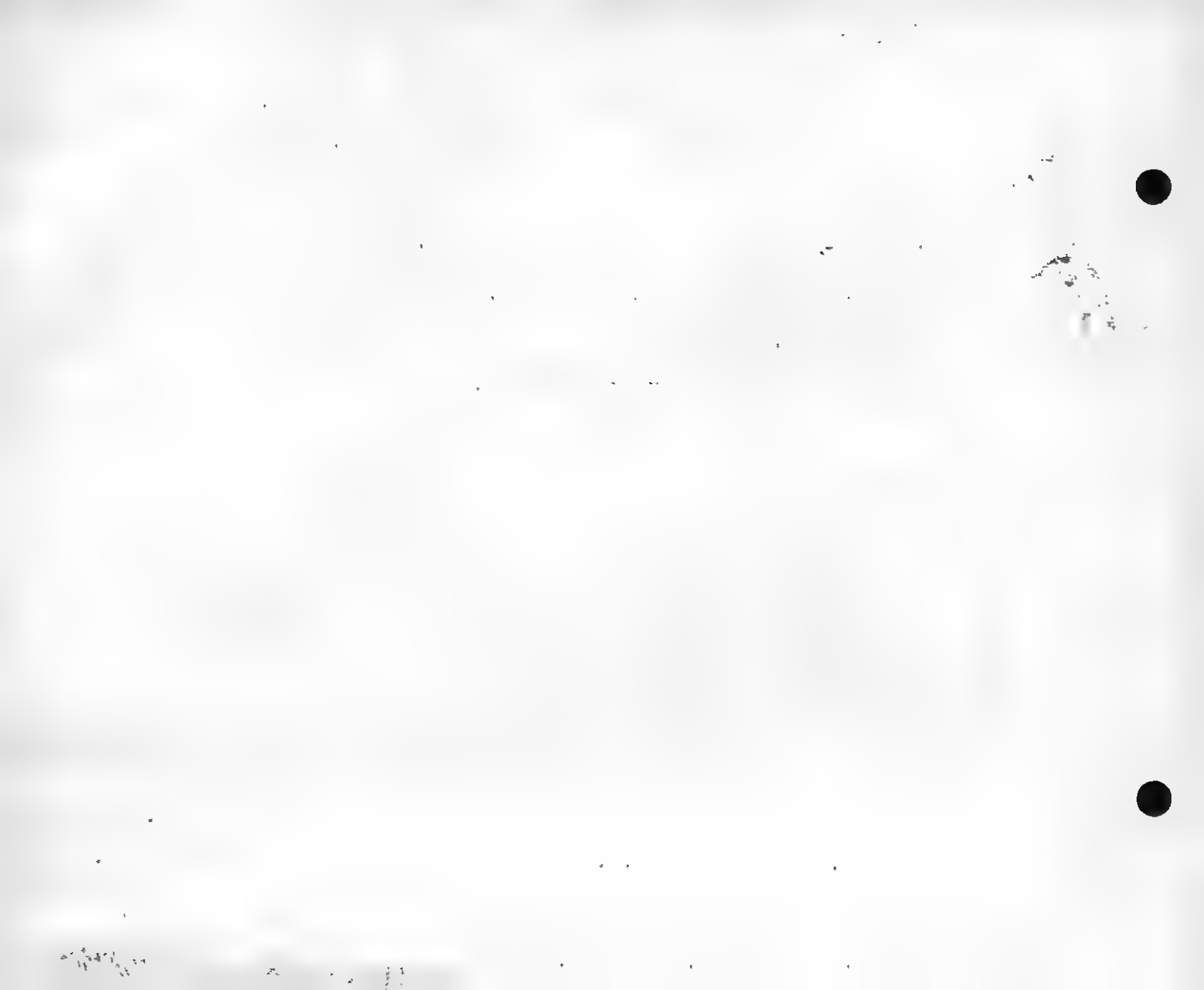


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VR A15
30M REV

12562										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12572																																							
1 DECEASED NAME										2a DATE OF DEATH										2b HOUR																																							
(Type or print)										Month Day Year										5A, M																																							
Annie Irene Foley										Sept. 20, 1968.										5A, M																																							
3 SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
Female										White										May 28, 1885.										83 YRS																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										USA																				Baltimore										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Balto. (Rural)										6306 Barbury Rd.										Housewife																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Balto.										Balto.										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										6306 Barbury Road																			
14. FATHER'S NAME										15. MOTHER'S M.A.D.E.N. NAME																																																	
First Middle Last										First Middle Last																																																	
Martin L. Ilgenfritz										Elizabeth										Marsheck																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										217-01-8015										Mrs. Elizabeth Gay										(Same)																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Congestive Heart Failure																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										Arteriosclerotic Cardiovascular Disease																																							
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
4221																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M.																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																											
22a. I certify that (I) (this hospital) attended the deceased from										Sept. 1958, to										9-20-1968, that (I) (we) last saw the deceased alive on										9/20/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																													
22b. SIGNATURE										M. X. Quinn MD										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																			
																																								Sept. 20, 1968																			
22a. PHYSICIAN'S NAME (Type)										M. Kevin Quinn, M.D.										22a. ADDRESS										1927 York Road Timonium, Md.																													
23a. BURIAL CREMATION REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										9/23/68.										Parkwood Cemetery										Baltimore, Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Leonard J. Ruck, Inc. Balto. Md. 21214																				DATE										SEP 24 1968																													
																														Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
LAURA			A.		Folkemer				Month 9 Day 16 Year 68		6:50 A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR	
Female			White			Oct. 3, 1939			78 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			USA						Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville			Summit Nursing Home			Partner - Folkemer			Photo			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		925 Poplar Grove St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
(late) John L. Becker			(late) Mary Baer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address						
						Mr. Paul L. Folkemer, 5920 Linthicum						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS												
4109 DUE TO, OR AS A CONSEQUENCE OF												
(b) ARTERIOSCLEROTIC C-U-R												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
420												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> at work <input type="checkbox"/>												
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1968, to 9/16, 1968, that (I) (we) last saw the deceased alive on 9/16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
CLIFF RATLIFF, JR.									9/16/68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
CLIFF RATLIFF, JR.			4605 EDMONDSON AVE #21									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			9-18-63			Loudon Park Cemetery			Baltimore, Maryland			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Witzke Fun. Dir., 4101 Edmondson Ave			21229			SEP 17 1968			J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1517-78
30M REV. 1-58

12564

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12574

1 DECEASED-NAME (Type or print) Irvin J. Forsyth			First Middle Last			2a. DATE OF DEATH Month Day Year Sept 21 68			2b. HOUR 3:45 P.M.			
3. SEX M		4 RACE Cauc.		5 DATE OF BIRTH July 17, 1891		6 AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.						
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1127 Gypsy Lane			12a. USUAL OCCUPATION (Kind of work done during life, even if retired) Researcher			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY I.M. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1127 Gypsy Lane			
14 FATHER'S NAME James Forsyth			First Middle Last			15 MOTHER'S MAIDEN NAME Mary Fisher			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218 36 8609		17 INFORMANT Mrs. Bertha E. Fossyth, Towson			Address				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 3/4 years												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4420												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from January 7, 1957 to September 21, 1968 , that (I) (we) last saw the deceased alive on September 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Grafton Newsperger DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED September 23, 1968				
22d. PHYSICIAN'S NAME (Type) W. Grafton Newsperger, M. D.		22e. ADDRESS 216 Medical Arts Building										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 24, 68		23c. NAME OF CEMETERY OR CREMATORY Lorraine				23d. LOCATION (City or Town) (County) (State) Baltimore, Baltimore, Md.				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.						25a. REC'D BY REGISTRAR DATE SEP 27 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
12565		12575									
1 DECEASED-NAME (Type or print) <u>First</u> <u>F. H. Henrich</u> <u>Middle</u> <u>Fox</u> <u>Last</u>						2a. DATE OF DEATH <u>September 12</u> <u>1968</u> <u>Year</u>			2b. HOUR <u>6 A.</u> <u>M.</u>		
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>March 4, 1874</u>		6 AGE (in years last birthday) <u>94</u> YRS		7 UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>1</u>		8 UNDER 24 HRS HOURS <u>1</u> MIN <u>1</u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md					
10 CITY OR TOWN OF DEATH <u>Towson</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Towson Convalescent Home</u>		12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Schools</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Towson</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>404 Dixie Drive</u>			
14. FATHER'S NAME <u>George Fox</u> <u>First</u> <u>Middle</u> <u>Last</u>						15. MOTHER'S MAIDEN NAME <u>Adeline Coe</u> <u>First</u> <u>Middle</u> <u>Last</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not (if yes give branch and grade) <u>No</u>		16b. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>Family records</u>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Inanition</u>										<u>1 month</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Senility</u>										<u>10 years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>44 X None Known</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, notify medical examiner)		21b. TIME OF INJURY <u>Hour</u> <u>12</u> <u>Month</u> <u>12</u> <u>Year</u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not while</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		21e. PLACE OF INJURY <u>AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.</u>		21f. LOCATION Street or R.F.D. No. <u>1210 York Road</u>		City or Town <u>Baltimore</u>		County <u>Baltimore</u>		State <u>Md.</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1967</u> to <u>Sept 12, 1968</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Aug 30, 1968</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>A.S. Chalkin</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Sept 12 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. A.S. Chalkin</u>		22e. ADDRESS <u>1210 York Road, Baltimore, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9/3/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Longfellow Chapel Cem.</u>		23d. LOCATION (City or Town) <u>Baltimore</u>		(County) <u>Baltimore</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns Son, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>							



CERTIFICATE OF DEATH

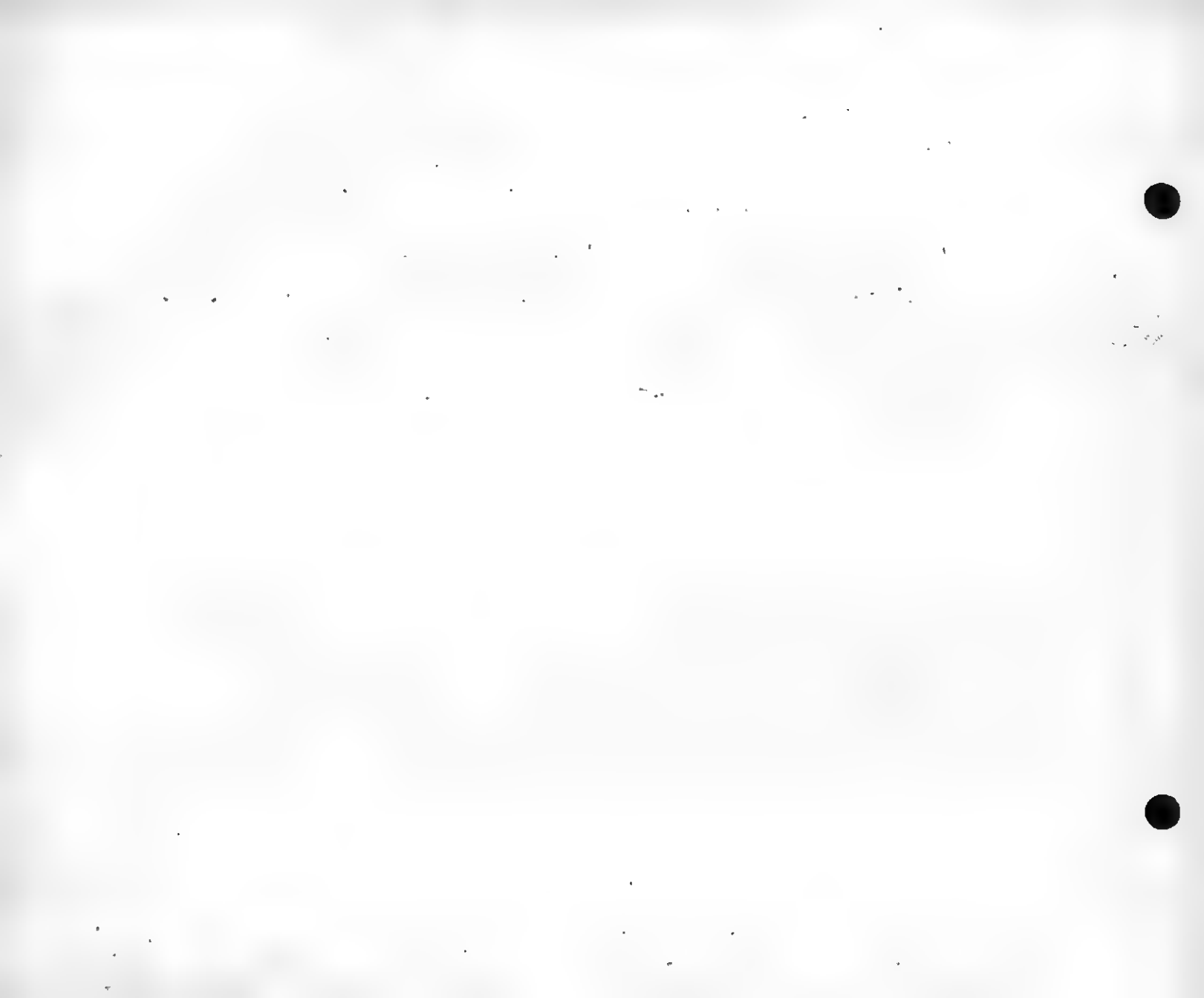
12566

12576

1. DECEASED NAME (Type or print) <i>Michael</i>		First		Middle		Last		2a. DATE OF DEATH Month <i>9</i> Day <i>30</i> Year <i>68</i>			2b. HOUR <i>6:25 P.M.</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Aug 23, 1897</i>			6. AGE (In years last birthday) <i>71</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i>								
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St Joseph Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Shoe Manufacturer</i>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>		13b. if institution Residence before COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1717 Northern Pkwy</i>							
14. FATHER'S NAME <i>Anthony</i>		First		Middle		Last		15. MOTHER'S MAIDEN NAME <i>Paulita</i>		First		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-03-915</i>		17. INFORMANT <i>Mrs Nellie Fria</i>			Address <i>Same</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4107</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ascaris</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1</i> <i>1</i> <i>1</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/25/68</i> , 19____, to <i>6/14/68</i> , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Robert Mahon M.D.</i>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10-2-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Robert Mahon M.D.</i>		22e. ADDRESS <i>204 East Joppa Rd Balto. Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/3/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>				23d. LOCATION (City or Town)		(County)		(State)			
24. FUNERAL DIRECTOR <i>Leonard J Ruck Inc, Baltimore, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>OCT 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John J. J...</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

12567

12577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) JOHN C. FRISCH SR.			2a DATE OF DEATH Month September Day 27 Year 1968			2b HOUR 9 A M	
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH February 27, 1898		6 AGE (in years lost birthday) 70 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Phoenix, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Blenheim & Dance Mill Rds.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Superintendent		12b KIND OF BUSINESS OR INDUSTRY Balt. County	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Phoenix		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER Blenheim Road		14 FATHER'S NAME First Charles Middle Frisch Last Stetner		15 MOTHER'S MAIDEN NAME First Bertha Middle Louise Last Stetner		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16b SOCIAL SECURITY NO 212-32-1950		17 INFORMANT John C. Frisch Jr.		Address Joppa, Md.		2606 Franklinville Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years						PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 46 , 19 46 , to 27 Sept , 19 68 , that (I) (we) lost the deceased alive on 27 Sept , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles H. Reier				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 27 Sept '68	
22d. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier				22e. ADDRESS 6701 York Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 30, 1968		23c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran Cem.		23d. LOCATION (City or Town) (County) (State) Sweet Air Balt. Co. Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.				ADDRESS 1050 York Road		25a. REC'D BY REGISTRAR SEP 30 1968	
				25b. REGISTRAR'S SIGNATURE Charles J. J...			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-3-68
304M RE 100

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
GAIL IVAN GALFORD						9 Month 1 Day 68 Year		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR	
Male		White		11/11/11		56 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
W. Va		U.S.		WIDOWED		BALTIMORE		PAPER FACTORY	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Catonville		Spring Grove State Hsp		PRESSMAN		PAPER FACTORY			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
MARYLAND		BALTO		CATONVILLE		YES NO		25 Frederick Rd	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
JAMES					GALFORD	LENA			CRAIG
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address
NO			203-10-8426			CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) respiratory failure									4 hrs
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (b) pulmonary emphysema + cor pulmonale									chronic
stating the underlying cause last (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
auto pneumonia									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES NO			
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f LOCATION (Street or R.F.D. No City or Town County State)			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a I certify that (I) (this hospital) attended the deceased from 6/13, 1962, to 9/2, 1968, that (I) (we) last saw the deceased alive on 9/2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						22c DATE SIGNED			
Frank B. Burgeson MD						9-2-68			
22d PHYSICIAN'S NAME (Type)						22e ADDRESS			
Frank B. Burgeson						711			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		9/5/68		Good Shepherd		Bellevue City		Md	
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
X B. B. B. 8778 Liberty Road						SEP 4 1968		Charles Judge	

12563

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12579

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2. DATE AND HOUR OF DEATH

1. NAME OF DECEASED
(Type or Print)

Burton E. Gant

Sept. 9, 1968

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

E. STREET AND NUMBER

1127 Gilmer St.

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Forrest Haven Nursing Home
315 Ingleside Avenue

5. SEX

Male

6. RACE

Negroid

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

2-23-02

9. AGE (In years
last birthday)

66

10. Under 1 Yr. Months Days ; 11. Under 24 Hrs. Hours ; Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Chester Gant

14. MOTHER'S MAIDEN NAME

Bessie Roberts

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

218039457

17. INFORMANT

Dorothy Gant (Aunt) 2017 Calbrook Av

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) slowing the
UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

CANCER OF ESOPHAGUS
& GENERALIZED METASTASIS

(B)

DUE TO, OR AS A CONSEQUENCE OF

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A)

22. I certify that (I) (this hospital) attended the deceased from 6/11/68 to 9/9/68

that (I) (we) last saw the deceased alive on 9/9/68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

John H. Shaw M.D.

DEGREE

Attending
PhysMed
DirectorStaff
Phys

23B. DATE SIGNED

9/10/68

23D. ADDRESS

DEGREE

5800 FARMERS AVE BALTO. MD

24A. BURIAL CREMATION, 24B. DATE
REMOVAL (Specify)

Burial

9-12-68

24C. NAME OF CEMETERY OR CREMATORY

Balto. Nat'l. Cem.

24D. LOCATION

Baltimore, Maryland

(State)

25A. DATE RECD BY HEALTH DEPT.

SEP 13 1968

25B. NAME OF REGISTRAR

John H. Shaw

25C. FUNERAL DIRECTOR

V.R. Bailey

ADDRESS

Kelson F. H. 1348 N. Calhoun St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers 1 and 2 and file with the State Dept. of Health sent to burial cremation removal.

ATTENTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12570 CERTIFICATE OF DEATH 12580									
1 DECEASED NAME (Type or print) First Middle Last Edith M. Garrettson			2a. DATE OF DEATH Month Day Year September 29 1968			2b. HOUR 8.50 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 3-24-1886		6 AGE (in years lost birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY (Lat. 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7820 Hillsway Ave., 21234			
14 FATHER'S NAME First Middle Last Howard J. Beck			15. MOTHER'S MAIDEN NAME First Middle Last Mary R. Riley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 215-10-2119D		17. INFORMANT Mrs Mary B. Ritter		Address 806 Edmondson Av			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiolar carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (a) (this hospital) attended the deceased from 9/18/ , 19 68 , to 9/29/ , 19 68 , that (b) (we) last saw the deceased alive on 9/29/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Christina Feliciano				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/30/68			
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.				22e. ADDRESS 7620 York Rd., Towson Md., 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24 FUNERAL DIRECTOR Sterling Funeral Estate 736 Edmondson Ave.				ADDRESS Baltimore Md 21204		25a. REC'D BY REGISTRAR OCT 2 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First Roscoe		Middle N.		Last Gary		2a DATE OF DEATH Sept. Month 7 Day 68 Year		2b HOUR 8:10 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11-23-92		6 AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) manager retired		12b KIND OF BUSINESS OR INDUSTRY Wholesale Grocery					
3a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE Maryland		13b. COUNTY Phoenix		13c. CITY OR TOWN Balt. Co.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7 Glenbrook Drive			
14 FATHER'S NAME First Middle Last William Walter Gary		15 MOTHER'S MAIDEN NAME First Middle Last Nancy Nelson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 213-05-8902A		17. INFORMANT Address Spring Grove Hospital Records (Wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia											
4x5x DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 491X Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-2 , 19 68 , to 9-7 , 19 68 , that (I) (we) last saw the deceased alive on 9-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. A. Lotfizadeh, M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-7-68	
22d. PHYSICIAN'S NAME (Type) M. HAMADA LOTFIZADEH		22e. ADDRESS Spring Grove State Hospital, Baltimore									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-10-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) Baltimore		(County) (State) Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd.		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151-4
30M REV 1-68

12572		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12582	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) <i>Ella Virginia Gatchell</i>			2a DATE OF DEATH Month <i>September</i> Day <i>25</i> Year <i>1968</i>			2b HOUR <i>2:00 P.M.</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Dec. 29, 1889</i>		6 AGE (In years lost birthday) <i>78</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Tenn.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md	
10 CITY OR TOWN OF DEATH <i>Monkton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>New County Rd.</i>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence, before admission) STATE <i>Md.</i>		13b COUNTY <i>Balto</i>		13c CITY OR TOWN <i>Monkton</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Joseph John</i> Middle <i>Gatchell</i> Last <i>Gatchell</i>		15 MOTHER'S MAIDEN NAME First <i>Laura</i> Middle <i>Ann</i> Last <i>Wells</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b SOCIAL SECURITY NO. <i>none</i>		17 INFORMANT Address <i>Mrs. Reba Hackler, Monkton, Md.</i>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>							<i>1 day</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>49</i>							<i>2-3 hrs</i>
(b) <i>Malnutrition</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Post Cholelithiasis</i>							<i>3-4 hrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-60</i> , to <i>9-25-68</i> , that (I) (we) last saw the deceased alive on <i>9-25-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. Herbert Mueller, MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>9-26-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>C. Herbert Mueller, MD</i>				22e. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>9/28/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Foster's Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Monkton Balto. Md.</i>	
24. FUNERAL DIRECTOR <i>James L. Hartenstein</i> ADDRESS <i>New Freedom, Pa.</i>				25a REC'D BY REGISTRAR <i>Oct 3 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12573

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12583

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Anna		Barbara	Gately	Sept. 13 1968		1025 M		
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
female	white		Sept. 23, 1896		71 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.		U.S.				Baltimore Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Catonsville		SPRING GROVE STATE HOSP.		housewife				
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Md.		Balto.		Dundalk				2745 Dungen Court
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		
Henry Zander						Wilhemina ?		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT			
No			213-07-6339		Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>								
DUE TO OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
4200								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (A) (this hospital) attended the deceased from April 12, 1967, to Sept. 13, 1968, that (A) (we) lost saw the deceased alive on Sept. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dia) (doctor) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				
Sherwood E. Wilson, M.D.		9/14/68		22e ADDRESS				
				SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		9/17/68		Balto. NATIONAL CEM.		Baltimore, Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
LEONARD J. RUCK, Inc.		BALTO. 21214		SEP 16 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

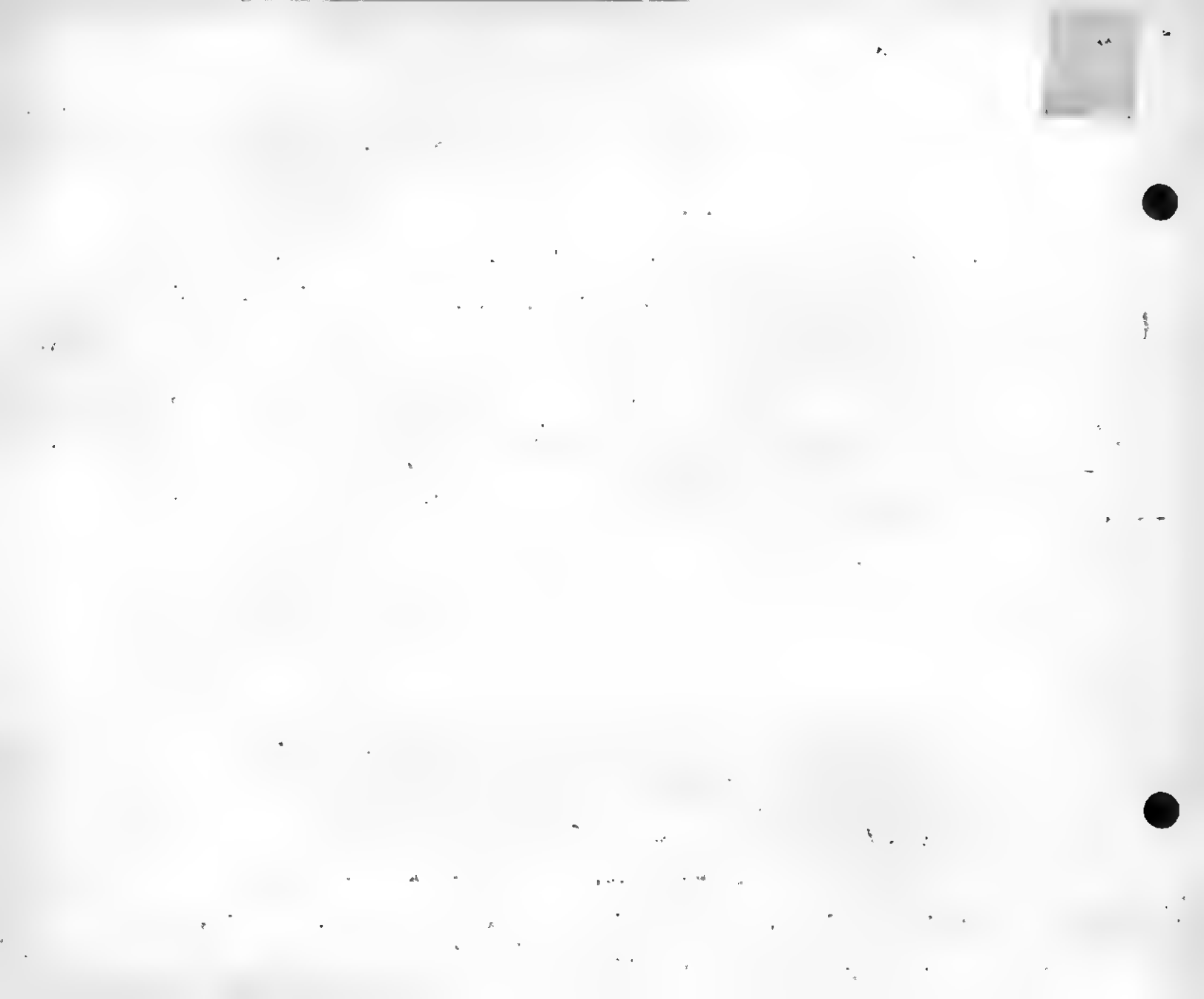
12574

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12584

CERTIFICATE OF DEATH

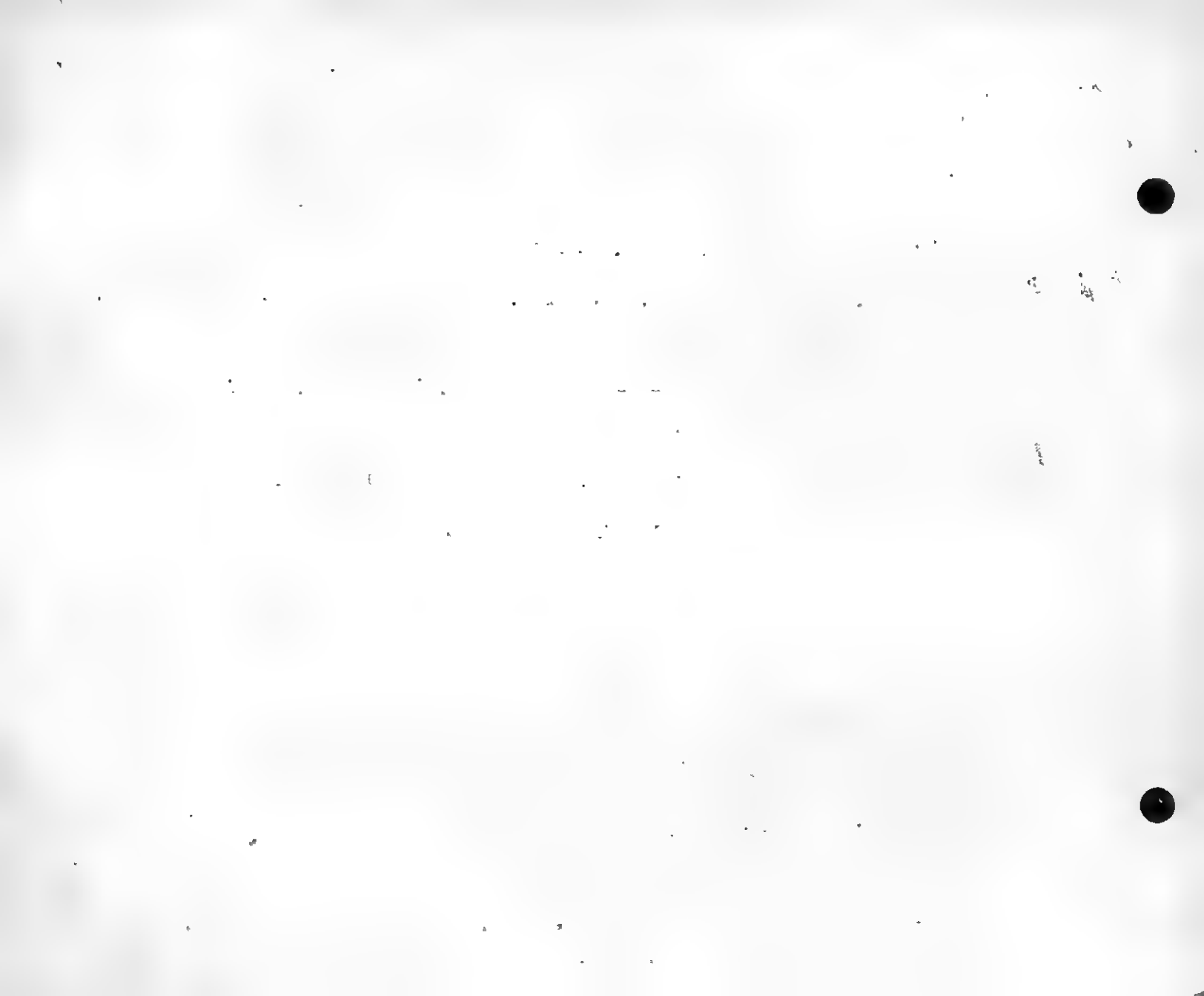
1. DECEASED-NAME (Type or print) Lanny		First Gene		Middle GATZKE		Last GATZKE		2a. DATE OF DEATH Month 9 Day 24 Year 68			2b. HOUR 7:20^{PM}	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 12/23/42		6 AGE (in years last birthday) 25 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) South Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent		12b. KIND OF BUSINESS OR INDUSTRY None						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2715 Rose Valley Drive				
14 FATHER'S NAME Lyle		First Edward		Middle Gatzke		Last Evelyn		15. MOTHER'S MAIDEN NAME First Dorothy		Middle Benthin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give year or dates of service) --		16b. SOCIAL SECURITY NO none		17 INFORMANT Address Rosewood Records, Owings Mills, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Abscess, Right 485 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Bacterizing Bronchial Pneumonia, Right DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 2 wks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 471x												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/29 , 19 68 , to 9/24 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/24 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (do not) view the body after death.												
22b. SIGNATURE Richard A. Jones		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/24/68		
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.										
23a. BURIAL, CREMATION, REMOVAL, SPECIFY		23b. DATE Oct 25 1968		23c. NAME OF CEMETERY OR CREMATORY Antietam National		23d. LOCATION (City or Town) Antietam, Md.		(County) Washington		(State) Md.		
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 1111 1st St. N.E.		25a. REC'D BY REGISTRAR DATE SEP 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12575		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12585	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First LORRAINE		Middle MARIE		Last GETZ	
2a DATE OF DEATH		Month SEPT.		Day 17		Year 1968	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH 1/21/26		6 AGE (In years last birthday) 42 YRS	
7a BIRTHPLACE (State or foreign country) Balto.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 404 S. Smallwood St.		14. FATHER'S NAME First Arthur		Middle Landon		Last Carrie Pilkerton	
15. MOTHER'S MAIDEN NAME First Carrie Pilkerton		Middle Carrie Pilkerton		Last Carrie Pilkerton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)	
16b SOCIAL SECURITY NO. 217-16-8417		17. INFORMANT Henry J. Getz		Address 404 S. Smallwood St., 21223			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF LUNG METASTASIS AND PLEURAL EFFUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARCINOMA OF THE LEFT BREAST DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE LEFT BREAST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-17 , 19 68 to 9-17 , 19 68 , that (I) (we) last saw the deceased alive on 9-17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE E.R. Souidj		DEGREE E. R. SOUDIJN, MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 9-17-68	
22d. PHYSICIAN'S NAME (Type) E. R. SOUDIJN, MD		22e. ADDRESS GR. BALTO. MED. CENTER					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/20/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS		25a. REC'D BY REGISTRAR SEP 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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1

12576

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12586

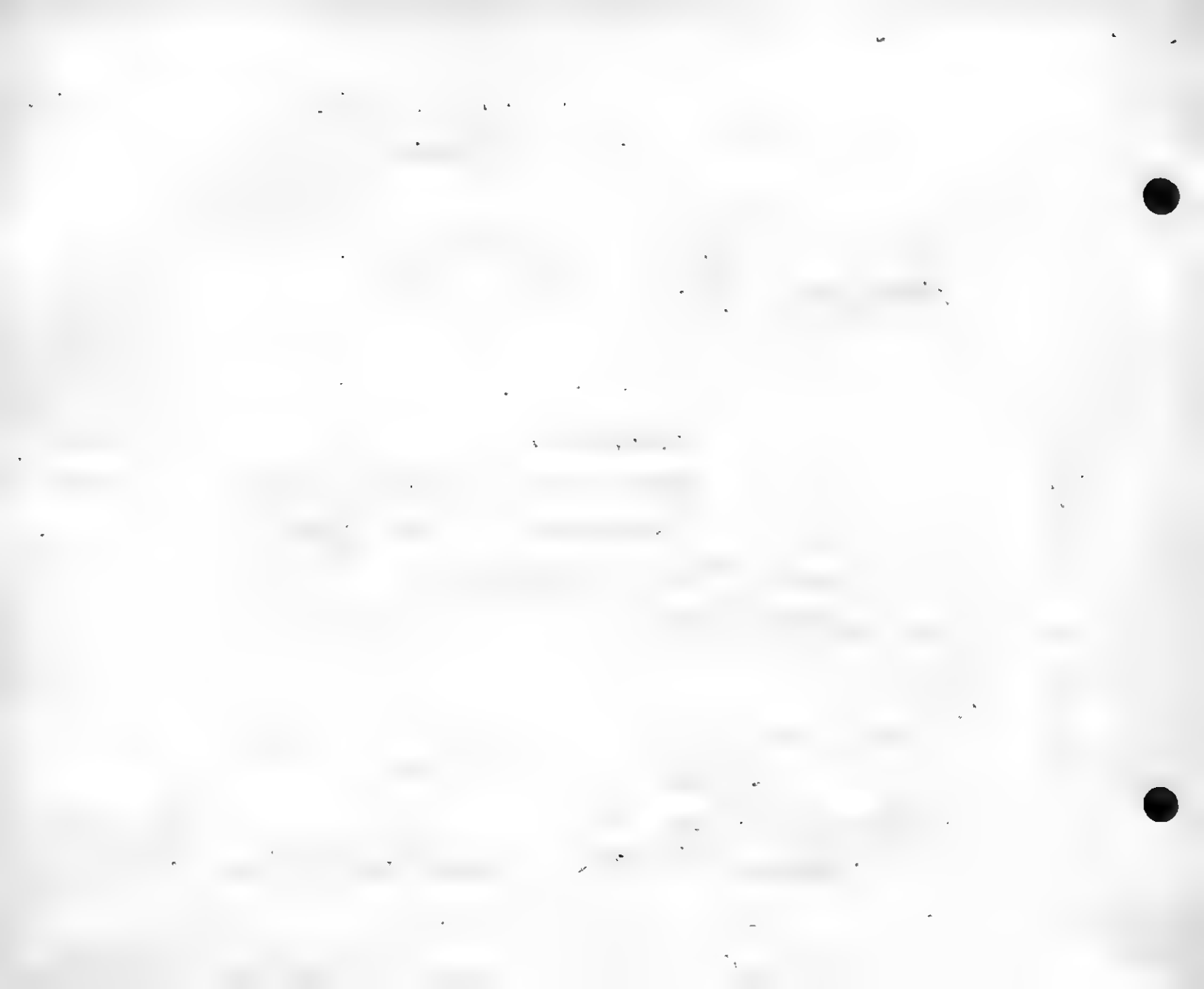
1 DECEASED-NAME (Type or print) MARTHA MALONE GILL			2a. DATE OF DEATH SEPT Month 28 Day 1968 Year			2b. HOUR 3 A M				
3 SEX F		4 RACE W		5 DATE OF BIRTH AUG. 19, 1929		6 AGE (In years last birthday) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.				
10. CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 2200 ELLEN AVE.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECTY		12b. KIND OF BUSINESS OR INDUSTRY ENG. CO.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2200 ELLEN AVE.		
14. FATHER'S NAME First Middle Last BUCK MALONE			15. MOTHER'S MAIDEN NAME First Middle Last RUTH -							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Dwight S. Gill - 2200 Ellen Ave. #34				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Psychoneurosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Malignant Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Alcohol								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 2 years 2 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 6000										
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) -						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) -		21f. LOCATION Street or R.F.D. No. City or Town County State -						
22a. I certify that (I) (this hospital) attended the deceased from January, 1966 , to Sept 28, 1968 , that (I) (we) last saw the deceased alive on Sept 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert T. Levy MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/28/68		
22d. PHYSICIAN'S NAME (Type) Robert T. Levy				22e. ADDRESS 114 Medical Arts Bldg. Balt						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-29-69		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) TARPON SPRINGS, FLORIDA			
24. FUNERAL DIRECTOR Dwight S. Gill				ADDRESS F.N. Catonville, Ind.		25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



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<div style="display: flex; justify-content: space-between;"> <div>12577</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 5 Film 6405 </div> <div>12587</div> </div>											
1. DECEASED-NAME (Type or print) LOUISA GOLDMAN						2a. DATE OF DEATH Sept 27 1968			2b. HOUR 1:30 A M		
3 SEX FEMALE		4 RACE Caucas.		5 DATE OF BIRTH 2/21/1901		6 AGE (in years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) ROMANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md					
10 CITY OR TOWN OF DEATH BALTO.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Milford Manor Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) MARTIN			13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. HOME CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7505 Marston Rd.		
14 FATHER'S NAME First MARTIN Middle WEISMAN Last TONI				15 MOTHER'S MAIDEN NAME First BLATTSTEIN Middle TONI Last BLATTSTEIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-03-6696		17 INFORMANT Address MRS. PHYLLIS ARONHEIM, 7505 MARSTON ROAD #7						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA										48 HRS	
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CANCER										10 months	
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE BREAST											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) URINARY TRACT INFECTION											
19a. DATE OF OPERATION June 1968			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenectomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY 9-27-68 HOUR A.M. P.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MARCH , 19 68 , to Sept 27 , 19 68 , that (I) (we) last saw the deceased alive on 9-27-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. Gerard Oster MD DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 9-27-68					
22d. PHYSICIAN'S NAME (Type) H. GERARD OSTER						22e. ADDRESS 6821 Reisterstown Road					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-29-68		23c. NAME OF CEMETERY OR CREMATORY RIGA KURLANDER VEREIN			23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND				
24 FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

12578

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12588

1 DECEASED NAME (Type or print) DORTHULAR GOODJINE			2a DATE OF DEATH Month Sept. Day 1 Year 1968			2b HOUR 5 36P M			
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH 2/27/83		6 AGE (In years lost birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md			
10 CITY OR TOWN OF DEATH Mount Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1805 DUKELAND Street	
14 FATHER'S NAME First Middle Last ? ? ?			15 MOTHER'S MAIDEN NAME First Middle Last ? ? ?						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no none		16b SOCIAL SECURITY NO. 217-56-7499		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 1127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 68 , to 9/1 , 19 68 , that (I) (we) last saw the deceased alive on 9/1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Newcomer		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9/10/68					
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Sept. 6, 1968		23c NAME OF CEMETERY OR PREMATORY New Catholic Cemetery Baltimore		23d LOCATION (City or Town) (County) (State) Baltimore Md.			
24 FUNERAL DIRECTOR Frank H. Howell		25a REC'D BY REGISTRAR SEP 13 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12572

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12589

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
MARY				FRANCES	GRANITE	SEPTEMBER 30, 1968			5:55 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
FEMALE			WHITE			AUGUST 8, 1904			64 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
ITALY			USA						BALTIMORE Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET AND NUMBER		
MARYLAND			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2806 GIBBONS AVE. #21214		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Vincent			Dacre			Eleanor			Irona		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No						Mrs. Elsie Picinotti			Edgewood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease</u> <u>27X X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral embolism</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>September 29, 1968</u> , to <u>September 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>September 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lilia C. Baldonado</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>9-30-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Lilia C. Baldonado, M.D.</u>						22e. ADDRESS <u>7620 York Road, Towson, Md. 21204</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10/3/68.			Holy Redeemer Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 2 1214</u>						25a. REC'D BY REGISTRAR <u>OCT 1 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

Iron

Edgewood, Md.

Attention

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12580

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BELFAST RD. near YORK ROAD		d. STREET ADDRESS BELFAST RD. near YORK RD	
3. NAME OF DECEASED (Type or print) First ELIZA Middle SCOTT Last GREEN		4. DATE OF DEATH SEPT. 18, 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1912
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY COURT HOUSE	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL T. HORNER		14. MOTHER'S MAIDEN NAME LOUISE G. KRAFT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO (b) Carcinoma of stomach (rectal) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1571X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 to Sept 18, 1968 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Jamshed Hamed		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMSHED HAMED		22d. ADDRESS Towson 8, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 19, 1968	
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CENT.		23d. LOCATION (City, town or county) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR John Korman's Sons, Towson		25a. REC'D BY REGISTRAR SEP 23 1968	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 8 & 13 Filed Nov. 8-11-68												
1 DECEASED NAME (Type or print)		First JOHN		Middle WILLIAM		Last GRIFFIN		2a DATE OF DEATH Month Day Year September 12, 1968			2b HOUR 4:30 P M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 11-5-1886			6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md						
10 CITY OR TOWN OF DEATH Halethorpe		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1824 Winans Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission), STATE Pennsylvania Md.		13b COUNTY Franklin		13c CITY OR TOWN Halethorpe		13d INSIDE CITY - IN TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1824 Winans Avenue 21227				
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b SOCIAL SECURITY NO. 207-22-5961		17 INFORMANT Burger Funeral Home 1315 Chestnut St						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 4 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X												
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No.		City or Town		County		State		
22a I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1968, to <u>9/12, 1968</u> , that (I) (we) last saw the deceased alive on <u>9/12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>James N. Frederick</u>				22c DATE SIGNED 9/12/68		22d. ADDRESS 1311 Francis Avenue, Balto., Md. 21227						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-15-68		23c NAME OF CEMETERY OR CREMATORY Congress Hill Cemetery		23d. LOCATION (City or Town)		(County)		(State)		
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		25a. RECD BY REGISTRAR SEP 16 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>								



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VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
12583																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First Dorothy			Middle Mae			Last Hall			2a. DATE OF DEATH Month Sept.			Day 15			Year 1968			2b. HOUR 8:42A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH APR. 26, 1930			6. AGE (In years last birthday) 38 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.														
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cntr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MD			13b. COUNTY BALTO			13c. CITY OR TOWN ESSEX			13d. INSIDE CITY, Y.M.T? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 2128 EASTERN AVE											
14. FATHER'S NAME First HENRY			Middle MCCAULEY			Last Last			15. MOTHER'S MAIDEN NAME First SADIE			Middle DOVEL			Last Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT ERNEST HALL			Address ABOVE														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage and hepatic failure</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver (post-hepatic)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5816																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> , 19 <u>68</u> , to <u>9/15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE John E. Adams			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Sept. 15, 1968														
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.			22e. ADDRESS 6701 N. Charles St. Towson, Md. 21204																				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9/18/68			23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL			23d. LOCATION (City or Town) (County) (State) BALTO. MD.														
24. FUNERAL DIRECTOR J.G. CONNELLY			ADDRESS 300 MACE			25a. REC'D BY REGISTRAR SEP 18 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge														

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The  requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15 (1)
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR P M	
Bernard Henry Hardesty						September		22	1968	6:15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
male		white		January 12, 1887		81					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.				Baltimore County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville			Spring Grove State Hospital			retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Prince George		Cheverly		2802 63rd Place				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Richard					Hardesty	Sarah					Faust
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
no			215-52-5609T		Bernard H. Hardesty, Jr.		4709-68th Ave. Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonic embolism											
450 X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 25, 1968, to Sept. 22, 1968, that I (we) last saw the deceased alive on Sept. 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
						Sept. 23, 1968					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Anthony J. Young, M.D.						Spring Grove State Hospital					
						Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9-26-68		Cedar Hill Cemetery		Suitland		Pr. Geo.		Md.	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wilhelm Funeral Home 4308 Suitland Rd. S. E.						DATE		SEP 26 1968			
											

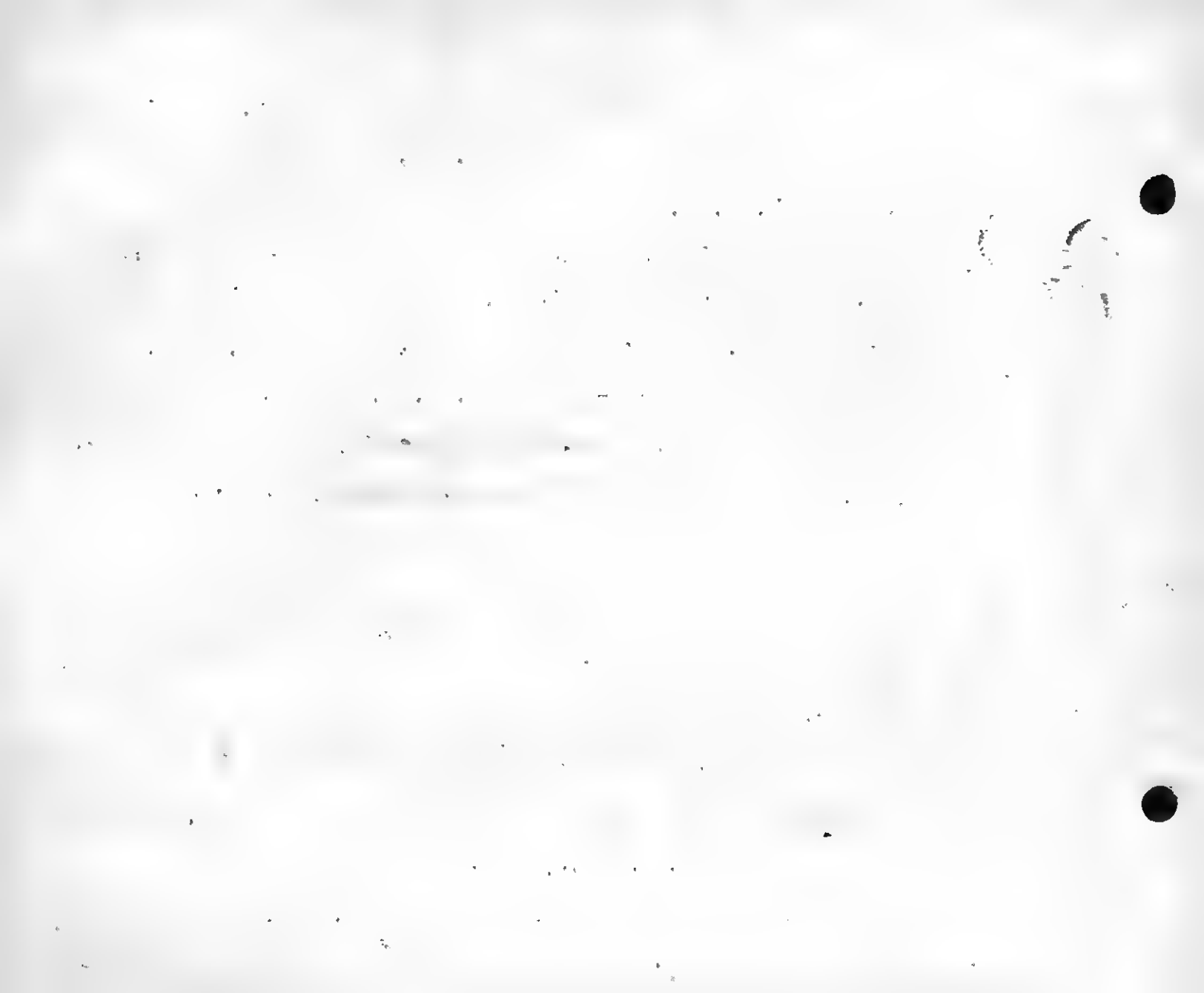
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Sallie Hopkins Hartmann						2a. DATE OF DEATH Month Day Year Sept. 24 1968			2b. HOUR 11 A.M.			
3 SEX F		4 RACE W		5. DATE OF BIRTH Nov. 16, 1891			6 AGE (in years lost birthday) 76 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Baltimore 21212			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 358 Old Trail			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore Balto. 12			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 358 Old Trail		
14. FATHER'S NAME First Middle Last Sidney J. Hopkins				15. MOTHER'S MAIDEN NAME First Middle Last Julia T. Lewis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 264-40-5462A			17 INFORMANT Mrs. A. L. Paternotte			Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion - 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes - 4 YRS.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1968 , to Sept. 29, 1968 , that (I) (we) last saw the deceased alive on Sept. 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. S. J. Venable, Jr. M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-25-68				
22d. PHYSICIAN'S NAME (Type) Dr. S. J. Venable, Jr.						22e. ADDRESS 7215 York Road						
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. - Burial		23b. DATE 9/26/68		23c. NAME OF CEMETERY OR CREMATORY Onnancock				23d. LOCATION (City or Town) (County) (State) Onnancock, Va.				
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.						ADDRESS 4905 York Road		25a. RECEIVED BY REGISTER SEP 26 1968		25b. REGISTER'S SIGNATURE J. C. Jones		
BALTO. 12, MD.												



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12580

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12596

1 DECEASED NAME (Type or Print) MARIAN HASTLER			2a DATE KNOWN OF ESTI- DEATH MATED 9-7-68			2b HOUR 9:00		
3 SEX F	4 RACE W	5 DATE OF BIRTH 2/12/10	6 AGE (in years last birthday) 58 YRS	7 UNDER YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD 9-7-68		
7a BIRTHPLACE (State or foreign country) MO		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		
10a CITY OR TOWN OF DEATH ESSEX		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 139 RIVERSIDE RD		12a OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b COUNTY BALTO.		13c CITY OR TOWN ESSEX		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 139 RIVERSIDE RD.
14 FATHER'S NAME First HARRIS Middle H Last H			15. MOTHER'S MAIDEN NAME First H Middle H Last H					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO		17 INFORMANT MARTIN HASTLER		ADDRESS ABOVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 A-C-V-DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4129 (b) 4221 DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 None								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 9-7-68 HOUR A.M. 19 P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE M.B. Davis			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 9/7/68		
EXAMINER'S NAME (Type) M.B. DAVIS			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b DATE 9/11/68			23c NAME OF CEMETERY OR CREMATORY LOUDON PARK		
24 FUNERAL DIRECTOR CONNELLY SONS			ADDRESS 300 MACE			25a REC'D BY REG STRAR SEP 11 1968		
						25b REG STRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12587

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12597

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Susie E Hatfield			2a. DATE OF DEATH Month Day Year September 2 1968		2b. HOUR and MIN 9:47 M
3. SEX Female	4. RACE White		5. DATE OF BIRTH 12/1/1879		6. AGE (In years last birthday) 88 YRS.
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore County			Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher	
12b. KIND OF BUSINESS OR INDUSTRY Music					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto.	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1404 Ellenglenn Rd.
14. FATHER'S NAME First Middle Last Edwin Craven			15. MOTHER'S MAIDEN NAME First Middle Last Amy Cavanagh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOC. A. SECURITY NO. 568056248A		17. INFORMANT Mr. George I. Hatfield- Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASCVD 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Lft hemiplegia - Generalized arthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 68 , to 9/2 , 19 68 , that (I) (we) last saw the deceased alive on 8/31 , 19 68 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Alan Tapper		DEGREE ATTENDING PHYSICIAN ALAN TAPPER		22c. DATE SIGNED 9/3/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7501 YORK RD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/6/68		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Warsaw, Indiana		24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR SEP 3 1968	
				25b. REGISTRAR'S SIGNATURE John Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Charles Sisco HAWKINS						2a. DATE OF DEATH Month 9 Day 29 Year 68			2b. HOUR 3:55 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 10-11-06			6 AGE (In years lost birthday) 61 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent			12b. KIND OF BUSINESS OR INDUSTRY none			
13a. U.S.A. RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8100 York Road				
14. FATHER'S NAME First Philip Middle Hopkins Last HAWKINS				15. MOTHER'S MAIDEN NAME First Laura Middle Belle Last Taylor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) ---		17. INFORMANT none		Address Rosewood Records, Owings Mills, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute necrotizing bronchial pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 49 yrs (b) Pulmonary Abscess formation Small, DUE TO, OR AS A CONSEQUENCE OF (c) 15 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 15 yr old child 56 yrs due to moderate mental retardation										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (H) (his hospital) attended the deceased from 6/7 , 19 65 , to 9/29 , 19 68 , that (H) (we) lost saw the deceased alive on 9/29 , 19 68 , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Richard A. Jones				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/30/68				
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.				22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Smith's Chapel Meth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Churchville, Harford Co., Maryland						
24. FUNERAL DIRECTOR Joseph William Foster				ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR OCT 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12589

12599

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
EARLAND		SPENCER	HAYE		Month 9 Day 16 Year 68		12:50 PM		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		6/3/17		51 YRS				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MAINE		U.S.A.				BALTIMORE COUNTY, Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VET. ADM. HOSPITAL		SOLDIER		US ARMY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		BALTIMORE		MIDDLE RIVER				9713 BIRD RIVER ROAD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
THOMAS		HAYE		CHRISTINE TAYLOR					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES		3/10/45-5/3/68		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY INFARCTION BILATERAL									
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOGENIC CARCINOMA OF RIGHT UPPER LOBE								UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE PERICARDITIS WITH EFFUSION								UNKNOWN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8/24/68, 19__, to 9/16/68, 19__, that (I) (we) last saw the deceased alive on 9/16/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
KRISHNA V. S. RAO, M.D.					D. VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4/19/68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH N. ZANNINO		SEP 19 1968		CHARLES JUDGE					
57 S. CONKLING ST. BALTIMORE, MD.									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. 5 may be retained for your files.

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VR A15MEH
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
Charles		E.	Heck		9-6	68	3		PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD	Month	Day
Male	White	Aug. 16, 1946	22 YRS				9-9	68	PM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH		10 CITY OR TOWN OF DEATH				
Maryland	U. S. A.		BALTO		Essex				
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			
Back River Balto 21		Laborer		Farboll Co.		Maryland			
13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8356 Bletzer Road			
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			
Ernest A. Heck Sr.			Catherine Montgomery			No (Yes, no, or unknown) (If yes give war or dates of service)			
16b SOCIAL SECURITY NO			17. INFORMANT (Father)			ADDRESS			
219-52-3618			Mr. Ernest A. Heck Sr.			8356 Bletzer Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - Compound</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>DOWNING</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
CAUSE OF DEATH			9-6 19 68		Fall from Boat				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or RFD No		City or Town		State	
		Back River		B/E Riverside Ave - Back River		Baltimore		Md - 21	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Sept. 9, 1968	
Melvin B. Davis						ADDRESS (Street, city, town, or county)		Dundalk, Md. 21222	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		9/11/68		Gardens of Faith Cemetery		Baltimore, Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
John J. Duda, 7922 Wise Ave. Dundalk, Md.						DATE SEP 13 1968		Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1-6, 8, 10-31 - 68 mt 406 Maryland State Department of Health
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12501

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
FRANCES						HELM		ESTIMATED MATED		9-4				1968		12:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		Month		Day		Year	
Female	White	Oct 4, 1906		61 YRS		MONTHS		DAYS		September 4,						1968 12:00 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Md		U S A		WIDOWED		DIVORCED		BALTIMORE									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Catonsville		Spring Grove Hospital		housewife		home											
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE		13b. CITY OR TOWN		3c. INSIDE CITY LIMITS?		13c. STREET AND NUMBER											
Md.		Catonsville		YES		Spring Grove Hospital											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M A D E N NAME		First		Middle		Last			
Reece E McLeod								Frances D									
16a. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
no		216 22 0880		Marshall E Helm		Berwyn Heights, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Interstital pneumonitis		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner																	
ACTUAL SIGNATURE		Charles S. Springate, M.D.		22b. DATE SIGNED		September 5, 1968											
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
Burial		Sept 7, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.											
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
F. Gaseh's Sons		Hyattsville, Md.		SEP 9 1968		Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

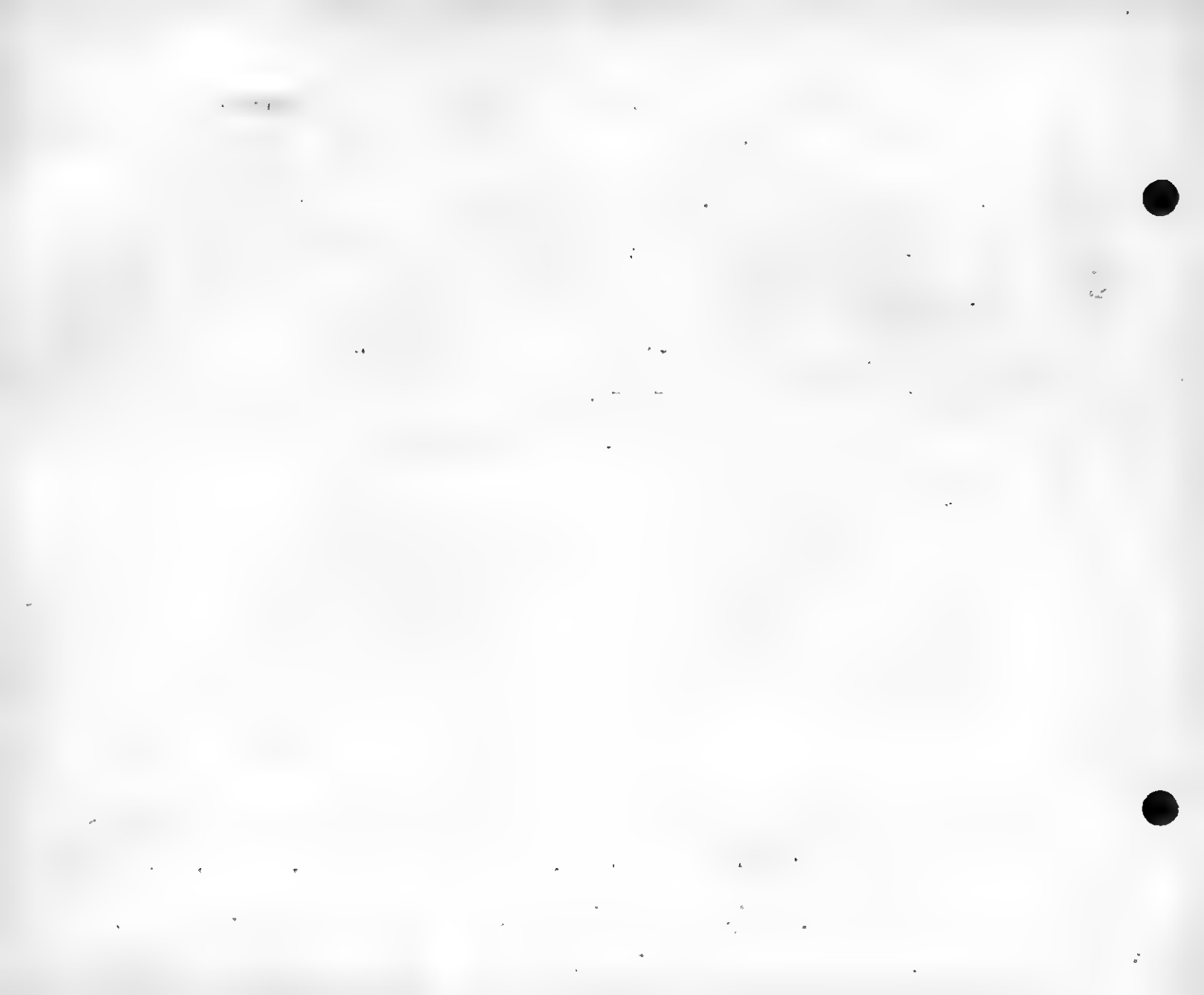
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) JOHANNA F. HILL						2a. DATE OF DEATH Month SEPT. Day 27 Year 1968		2b. HOUR 1:05A M	
3 SEX F		4 RACE W		5. DATE OF BIRTH 10/12/81		6 AGE (In years last birthday) 86 YRS.		7 UNDER 1 YEAR MONTHS 8 DAYS 15	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.			
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 500 DORSEY AVE		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 500 DORSEY AVE	
14. FATHER'S NAME First FREDERICK Middle FRIESE Last ?				15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NAK		16b. SOCIAL SECURITY NO.		17. INFORMANT ANDREW HILL		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 28 YEARS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 42									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/26 , 19 62 , to 9/27 , 19 68 , that (I) (we) last saw the deceased alive on 9/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Niceli		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/27/68			
22d. PHYSICIAN'S NAME (Type) JOSEPH NICELI, M.D.		22e. ADDRESS 105 S. TAYLOR AVE		ESSEX, MD.		21221			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORY CAK LAWN		23d. LOCATION (City or Town) (County) (State) BALTO. MD.			
24. FUNERAL DIRECTOR J.G. CONNELLY		ADDRESS SOMS		25a. REC'D BY REGISTRAR 300 MACE		DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Ruth			Middle C.			Last Hinkle			2a. DATE OF DEATH Month Day Year September 7, 1968			2b. HOUR 2:45p M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH March 4, 1900			6. AGE (In years last birthday) 68 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md								
10. CITY OR TOWN OF DEATH Towson 21204			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3037 Shannon Dr. #21213					
14. FATHER'S NAME First ?			Middle Lurz			Last Josephine			15. MOTHER'S MAIDEN NAME First Josephine			Middle Schroeder			Last Schroeder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 219-12-5239			17. INFORMANT Mrs. Ruth J. Guckert			Address (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive Pulmonary Embolism																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
465x																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 8/26/1968, to 9/7/1968, that (I) (we) lost the deceased alive on 9/7/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Christine Feliciano M.D.			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-7-1968								
22d. PHYSICIAN'S NAME (Type) Christine Feliciano M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204														
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/11/68			23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.								
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR SEP 9 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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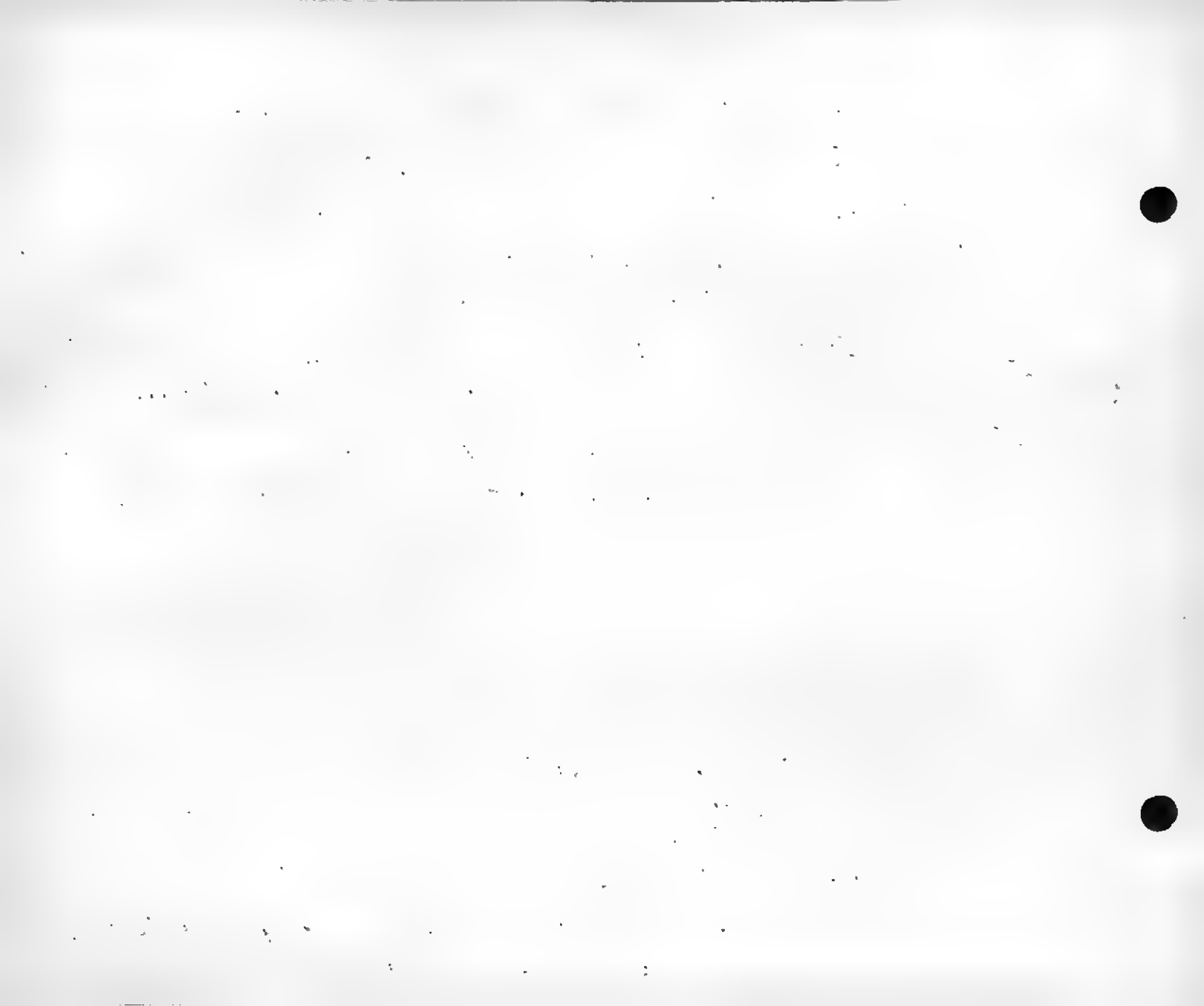
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Terrence M. Hoshall						2a. DATE OF DEATH Month Sept. Day 30 Year 68			2b. HOUR 10 P. M.		
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH July 18, 1904		6 AGE (In years last birthday) 64 YRS.		7f UNDER 1 YEAR MONTHS DAYS 		7g UNDER 24 HRS. HOURS MIN 	
7a BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10. CITY OR TOWN OF DEATH White Hall				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hunter Mill Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bus Driver			12b KIND OF BUSINESS OR INDUSTRY Own Bus		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE md.				13b COUNTY Balto		13c CITY OR TOWN White Hall		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Hunter Mill Rd	
14. FATHER'S NAME First Thomas M. Middle Hoshall Last Hoshall						15. MOTHER'S M.A.D.E.N. NAME First Chloe Belle Middle Miller Last Miller					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or in (specify) No				16b SOCIAL SECURITY NO. 214-03-6297		17 INFORMANT Ada S. Hoshall, Hunter Mill Rd. White Hall, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 412.7 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 420.0 (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma T. Th.											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1920 , to 9/30 , 19 68 , that (I) (we) last saw the deceased alive on 9/28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. M. France						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/1/68			
22d. PHYSICIAN'S NAME (Type) A. M. FRANCE						22e. ADDRESS P. 7 RIXTON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/3/68		23c. NAME OF CEMETERY OR CREMATORY Vernon Cem.		23d. LOCATION (City or Town) (County) (State) White Hall, Balto., Md.					
24. FUNERAL DIRECTOR James J. Horstenstein, New Freedom, Pa.						25a. REC'D BY REGISTRAR OCT 4 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV 1-58

12593										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12608																													
CERTIFICATE OF DEATH																																																	
1 DECEASED NAME (Type or print) HELEN MARIE HOFF										2a DATE OF DEATH 9-17-68										2b HOUR M																													
3 SEX FEMALE										4 RACE WHITE										5 DATE OF BIRTH OCT. 16, 1887										6 AGE (In years last birthday) 80 YRS.																			
7a BIRTHPLACE (State or foreign country) MARYLAND										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md.																			
10. CITY OR TOWN OF DEATH ROCKDALE										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7719 LIBERTY RD										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK																			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND										13b. COUNTY BALTIMORE ROCKDALE										13c CITY OR TOWN ROCKDALE										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e STREET AND NUMBER 7719 LIBERTY RD									
14 FATHER'S NAME First GEORGE Middle WALTER Last ROSE										15. MOTHER'S MAIDEN NAME First ROSE Middle CORNE Last CORNE										16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war and dates of service)										16b SOCIAL SECURITY NO.										17 INFORMANT DAUGHTER Address MRS. DORIS SCHWARTZ MARIOTTVILLE, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 1. DEATH WAS CAUSED BY:																																																	
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS										5 DAYS																																							
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE C.V. DISEASE										3 YEARS																																							
DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from OCT 10, 1950 , to SEP 13, 1968 , that (I) (we) saw the deceased alive on 9/16 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b SIGNATURE Edwin L. Pierpont										DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c DATE SIGNED 9/17/68																													
22d. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD										22e ADDRESS 8204 LIBERTY RD. BALTO, 21207 MD.																																							
23a BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 9-20-68										23c NAME OF CEMETERY OR CREMATORY LORRAINE Cemetery - BALTO, Md.										23d. LOCATION (City or Town) (County) (State)																			
24. FUNERAL DIRECTOR Elsworth Armacost										ADDRESS 4600 Liberty Ave.										25a REC'D BY REGISTRAR SEP 19 1968										25b REGISTRAR'S SIGNATURE Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Aubrey Monroe Hudgins						September 28, 1968			12.00			
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Nov. 4, 1930			37 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		U.S.A.					Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Reisterstown			115 First Avenue			Supervisor			Black & Decker Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland			Baltimore			Reisterstown			13e. STREET AND NUMBER			
									115 First Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Gordon Watson Hudgins			Nannie Rebecca Allander									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address			
Yes			1948-1952			213-26-2976			Mrs. Ann Hudgins 115 First Avenue Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest											15 mins.	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis											5 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic C.V. Disease												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1968, to Sept. 28, 1968, that (I) (we) last saw the deceased alive on Sept. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. DATE SIGNED								9-30-68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Martin E. Strobel, M.D.						59 Hanover Rd. Reisterstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial		Oct. 2, 1968		Reisterstown Meth. Cem.				Reisterstown, Balto., Md.				
24. FUNERAL DIRECTOR				ADDRESS				25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. J. Eckhardt				Owings Mills, Md.				OCT 3 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-54

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12597 CERTIFICATE OF DEATH 12597									
1 DECEASED-NAME (Type or print) John A. Hugg, III			First Middle Last		2a. DATE OF DEATH Month Day Year 9-21-68			2b. HOUR A 2:30 M	
3. SEX Male		4 RACE Cauc.		5 DATE OF BIRTH 6-28-50		6 AGE (In years last birthday) 18 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.	
10. CITY OR TOWN OF DEATH Timonium		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 408 Ivy Church Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 408 Ivy Church Rd.	
14 FATHER'S NAME John A. Hugg, Jr.			First Middle Last		15 MOTHER'S MAIDEN NAME Jeane Bryant				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT John Hopkins Medical Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Refuscular Septicopy DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? X-yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/20 19 68 to date 19 68 , that (I) (we) last saw the deceased alive on 9/20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Louis D. Pratt, Jr.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/23/68			
22d. PHYSICIAN'S NAME (Type) Louis D. Pratt, Jr.		22e. ADDRESS 8402 Drexway Rd		1-20234					
23a. BURIAL, CREMATION, RENOVATION (Specify)		23b. DATE 9-24-68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or town) (County) (State) Cockeysville, Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.				ADDRESS		25a. RECD BY REGISTRAR SEP 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12598

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12608

1 DECEASED NAME (Type or Print) SARAH JANE HUNTER			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9-20 1968			2b. HOUR P 2:50 M		
3 SEX Female	4 RACE White	5. DATE OF BIRTH	6 AGE (In years last birthday) 75 YRS	7. UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 9 Day 20 Year 1968		
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Home-maker		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3231 Elmley Avenue
14. FATHER'S NAME First Middle Last Hunter				15. MOTHER'S M A D E N NAME First Middle Last Mary Connors				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 218-52-1314		17. INFORMANT ADDRESS Mary A. Heath, neice, 3231 Elmley Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-21-68		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				DATE SEP 24 1968		J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

12599

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12609

1 DECEASED-NAME (Type or print) GENEVIEVE T HYMAN			2a DATE OF DEATH Month September Day 25 Year 1968			2b HOUR 10:45 PM					
3 SEX Female		4 RACE White		5 DATE OF BIRTH January 14, 1882		6 AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HWT - retired			12b KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Towson		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1634 Mussels Rd. 21204	
14 FATHER'S NAME First Joseph Middle Sweigler Last			15 MOTHER'S MAIDEN NAME First Theresa Middle Murphy Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO (If yes give year or dates of service)			16b SOCIAL SECURITY NO 215-14-9462D			17 INFORMANT Family Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral ischemia 4347 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral embolism DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 25, 1968 to Sept. 25, 1968 , that (I) (we) last saw the deceased alive on Sept. 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/26/68			
22d. PHYSICIAN'S NAME (Type) Ines Gilliani, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Sept. 28, 1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR John Burns Sons, Towson, Md.						25a. REC'D BY REGISTRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
12600									
12610									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ETTA			F.		JACOBS	SEPTEMBER 16, 1968		1:30A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
FEMALE		WHITE		APRIL 15, 1880		88 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
LATVIA		U.S.A.				BALTIMORE Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		CHESAPEAKE MANOR NURSING HOME		HOUSEWIFE		AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
NEW YORK				NEW YORK		YES <input type="checkbox"/> NO <input type="checkbox"/>		49 E. 96th Street	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
ABRAHAM					FREEDENBERG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
NO			074-42-4757J1		MRS. DOROTHY J. OSSERMAN		49 E. 96th STREET NEW YORK, NEW YORK		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Chronic decubitus ulcers.</u>									
(c) <u>Cerebral Vascular Accident</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1968</u> , to <u>Sept 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <u>Frances T. Daley</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <u>9/16/68</u>									
22d. PHYSICIAN'S NAME (Type) <u>FRANCES T. DALEY</u> 22e. ADDRESS <u>3201 N. CHARLES STREET</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE <u>9-17-68</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u> 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>									
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> 25a. REC'D BY REGISTRAR <u>SEP 17 1968</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12601		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12611	
Item#10 Film#G404 9/22/68 vmp					
1. DECEASED-NAME (Type or print) EUGENE U. JEANNERET			2a. DATE OF DEATH Month SEPT. Day 12 Year 1968		2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH AUG. 7, 1887		6. AGE (In years lost birthday) 81 YRS	7. UNDER-1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) MO.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6942 GERMAN HILL RD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN	13d. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6942 GERMAN HILL RD
14. FATHER'S NAME First ? Middle ? Last ?			15. MOTHER'S MAIDEN NAME First ? Middle ? Last ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT EMILY PETITT Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4221 (b) intermediate cardiac ischemia DUE TO, OR AS A CONSEQUENCE OF (c) depression					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Mar. 8, 1961 to 9-12, 1968 , that (I) (we) last saw the deceased alive on 9-11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Benigno R. Lazo MD		DEGREE MD		22c. DATE SIGNED 9-13-68	
22d. PHYSICIAN'S NAME (Type) BENIGNO R LAZARO		22e. ADDRESS 69 Dundalk Ave. Balt. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/16/68		23c. NAME OF CEMETERY OR CREMATORY BALTO. CEM.	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MALE		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
25a. REC'D BY REGISTRAR J.G. CONNELLY SONS		25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE SEP 19 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

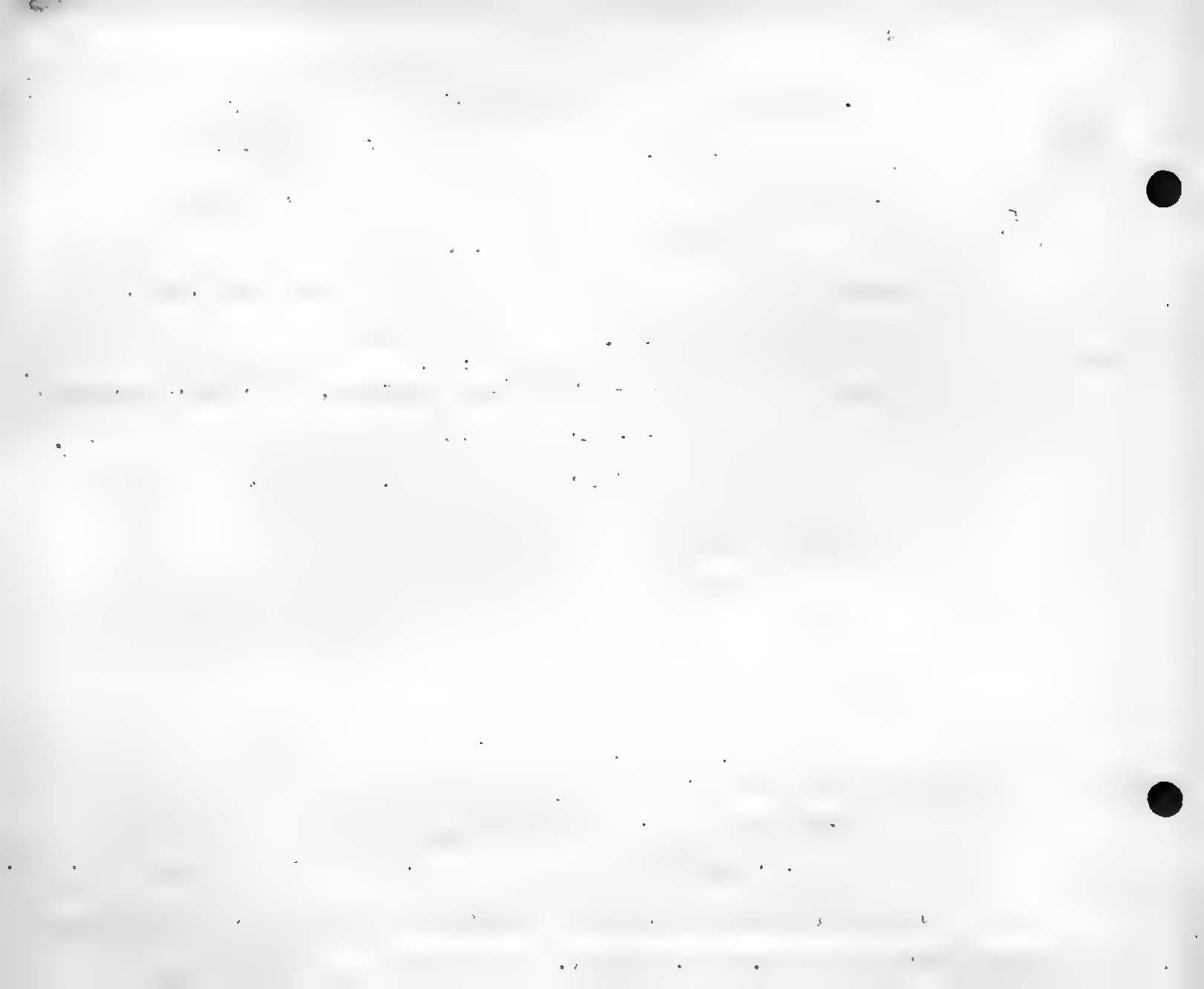
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12602

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
HILDA				Joerdens	9/1/68		1:40 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.
Female	white		2/21/37		81 82 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Baltimore	USA				BALTIMORE			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
TOWSON		Chesapeake Manor N.H.			NONE			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland				City of Balto		568 W.Univ.Pkwy.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
John Christian Bittorf					Mary Kalmey			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
NO		213-48-7316		son		Md.		
		Philip J. Joerden		568 W.Univ.Pkwy. Balto.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>								2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma of breast</u>								2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION								
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
			HOUR A.M. Month Day Year					
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <u>July 10, 1968</u> to <u>Sept 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE			22c. DATE SIGNED					
<u>A. Allan Spier</u>			9/1/68					
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS					
A. ALLAN SPIER			1501 Pentridge Road, Balto., Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		9/4/68		Loudon Park Cemetery		Baltimore, Maryland		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
STEWART & MOWEN CO.		108 W. North Av., City 1		DATE SEP 4 1968		<u>[Signature]</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
12605 CERTIFICATE OF DEATH 12612														
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR					
CHARLIE ALSO: CHARLES			JOHNSON JOHNSON			Month Day Year 9 12 68			10:50 AM					
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS			
MALE		NEGRO		6/5/97			71 YRS.		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
BALTIMORE, MARYLAND			U.S.A.						BALTIMORE COUNTY,			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD			VET. ADM. HOSPITAL			MASON			BRICK					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		211 N. Monroe Street				
14 FATHER'S NAME			First Middle Last			5 MOTHER'S MAIDEN NAME			First Middle Last					
WILLIAM			JOHNSON			DORA			MADDOX					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, name of unit or branch of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address								
YES			WW II			217 01 78 29			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG WITH WIDESPREAD METASTASES												UNKNOWN		
1621 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No.			City or Town			County State		
22a. I certify that I (this hospital) attended the deceased from 9/4/68, 19, to 9/12/68, 19, that (we) last saw the deceased alive on 9/12/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (do not) view the body after death.														
22b SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED					
ERHARD J. BUNYOR									9/12/68					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
ERHARD J. BUNYOR, M. D.			VAH FORT HOWARD, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL			9-16-68			BALTIMORE NATIONAL			BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
			MORTEN & DYETTE FUNERAL HOME			DATE 9/10/68			y Charles Judge					
			1701 Laurens St. Balto. Md.											



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Item 18 Film 405 10-8-68a MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12614				
12604					CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR					
Herman J. Jones						Sept. 24 1968			7 ⁰⁰ A M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.			
M		W		8-5-1905			63 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D-VORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Virginia			U. S. A.						w Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Arbutus			5521 Link Avenue 21227			Machinist			Koppers Co.					
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore			Arbutus					5521 Link Avenue			
14. FATHER'S NAME First Middle Lost					15. MOTHER'S MAIDEN NAME First Middle Lost									
John Jones					Cora (Unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			212-09-8653			Agnes E. Jones 5521 Link Ave.			Arbutus Md. 27					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 1977 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Unknown, possible liver.</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>65</u> , to <u>9/24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>9/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <u>James N. Frederick</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>9/24/68</u>						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
James N. Frederick						1311 Francis ave.		Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)		
Burial			9-27-68		Lorraine Park Cemetery			Woodlawn, Md.						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE						
Howard H. Hubbard, 4107 Wilkens Ave. 21229						SEP 27 1968		<u>Charles Judge</u>						



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VR A15
30M REV 11-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12605 Items#2a,6, per tele. con. 9/25/68 km. 12615											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		
							KALB.		9 17 1968		
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
M			W			9/17/68			68 YRS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Md			U.S.A						BALTO		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
BALTO			GR BALTO Med Center			0			0		
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Balto			Balto			8006 Hayford Rd		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
GERARD			None			KALB			Unknown		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17. INFORMANT			Address		
No			0			V-C Kelly, Md			7215 York Rd 21222		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.										10 min	
IMMEDIATE CAUSE (a) Anoxia											
7762 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) Respiratory failure respiration never initiated											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Premature Birth											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No			City or Town		County State
22a I certify that (I) (this hospital) attended the deceased from 1:45 AM 9/16/68, to 1:45 AM 9/16/68, that (I) (we) last saw the deceased alive on 9/16/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			22c DATE SIGNED								
Vernon C Kelly, MD			9/17/68								
22d PHYSICIAN'S NAME (Type)			22e ADDRESS								
			7215 York Rd.								
23a BURIAL, CREMATION OR REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
9-2068			9-2068		Greater Balto. Med. Center			Towson Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
R Breitenacker						SEP 23 1968			J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to be funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

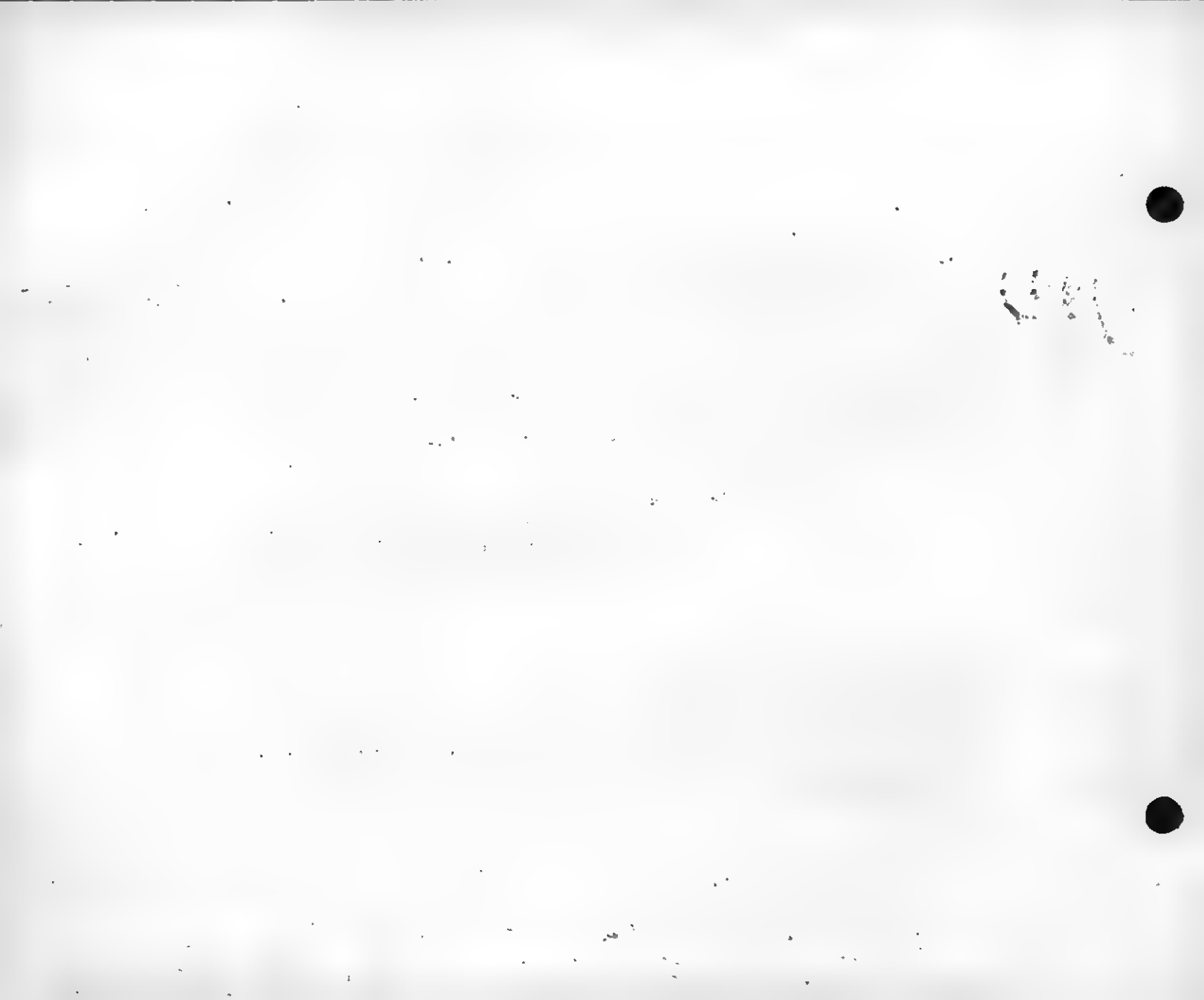
1

12606

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12616

1 DECEASED-NAME (Type or print) First Middle Last <i>Lula Katz</i>			2a DATE OF DEATH 9 Month 20 Day 68 Year			2b HOUR 3 P. M.	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>6/8/1894</i>		6 AGE (In years last birthday) <i>74</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.	
10 CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hausman Plaza Catonsville</i>		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>410 W. Franklin St.</i>		14. FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Jerry Sopher</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Ventricular Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ch. Arteriosclerotic Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Dis.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>3 hr.</i> <i>10 hr.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>433</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-10</i> , 19 <i>63</i> , to <i>9-20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-20</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.							
22b. SIGNATURE <i>Wilmer K. Gallagher M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9-21-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>				22e. ADDRESS <i>6209 Frederick Ave. Baltimore, Md. 21228</i>			
23a B. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b DATE <i>9/24/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>HECREW SPRINGFIELD</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. J. Trachtenberg Sons Baltimore, Md.</i>				25a REC'D BY REGISTRAR DATE <i>OCT 2 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



12607

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) Kenneth M. Keefer			2a. DATE OF DEATH Month Sept Day 12 Year 68			2b. HOUR 1:10am			
3 SEX Male		4 RACE White		5. DATE OF BIRTH June 30, 1916		6 AGE (In years last birthday) 52 YRS		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. County Towson Md.			
10. CITY OR TOWN OF DEATH Towson Md.		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Dulaney Towson Nursing Home (Terminal Manager)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Transfer & Storage			
13a. USUA. RES-DENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Union Bridge Md.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6505 Laurel Drive	
14 FATHER'S NAME First Middle Last McClellan Keefer			15 MOTHER'S MAIDEN NAME First Middle Last Natalie Haines						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO 213-01-3360		17 INFORMANT Mrs. Bernice K. Jones		Address 6505 Laurel Drive 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1971 Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) TO DUE TO, OR AS A CONSEQUENCE OF (c) SEPT 12, 68									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH From Apr. 24/68
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1992									
19a. DATE OF OPERATION APR 24, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RLQ MASS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. L.H. COLOMBEK		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 2039 LIBERTY RD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/14/68		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.		23d. LOCATION (City or Town) (County) (State) Co. Union Bridge Maryland, Balto.			
24. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd. 21133		25a. REC'D BY REGISTRAR SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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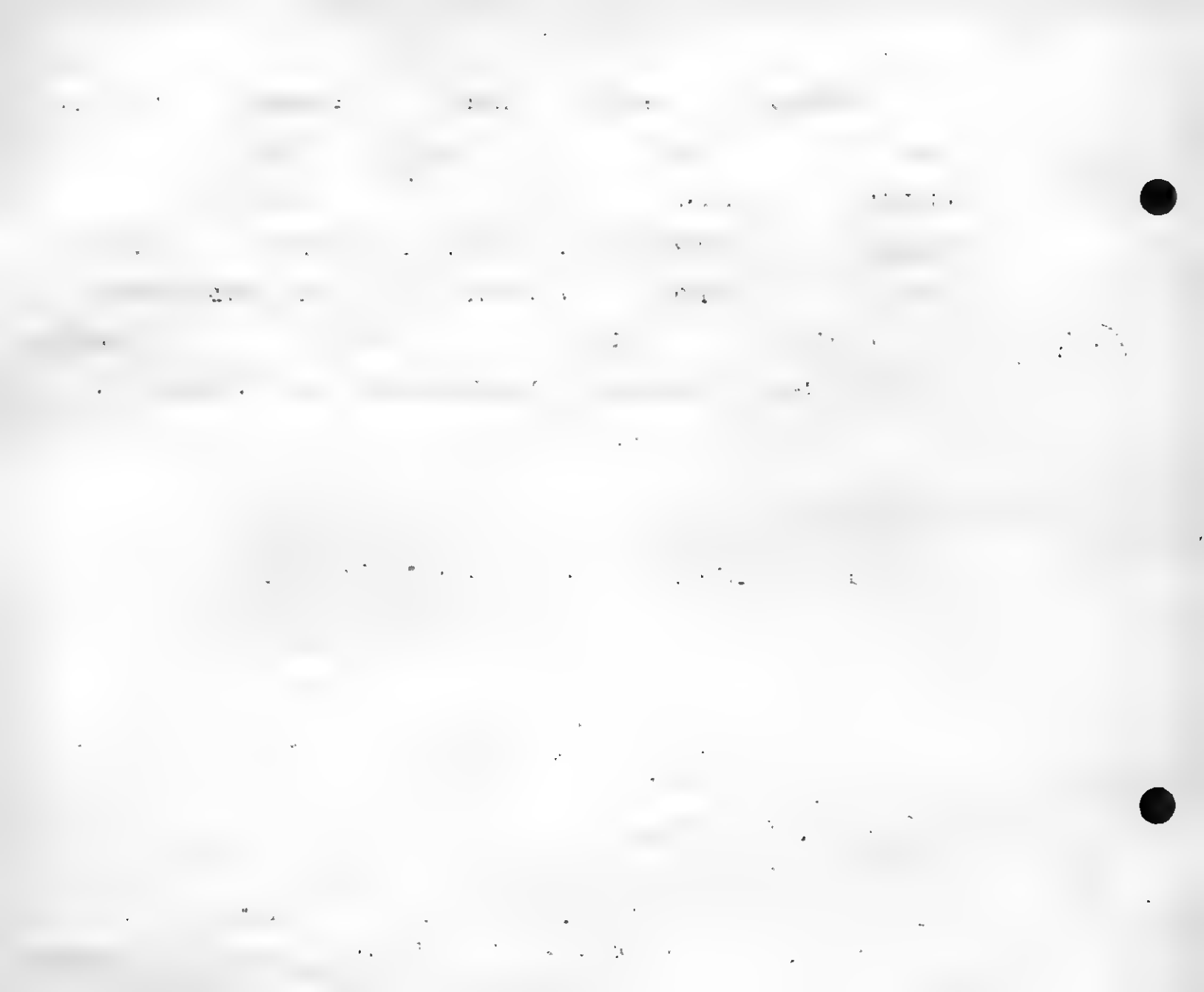
12608

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12618

1. DECEASED-NAME (Type or print) FREDERICK EDWARD KEENE			2a. DATE OF DEATH Month SEPTEMBER Day 9 Year 1968			2b. HOUR 5:05A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7/13/18		6. AGE (in years last birthday) 50 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LITHOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY PRINTING	
13a. USUAL RESIDENCE (Where deceased lived, if not in an institution before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last HARRY - - KEENE		15. MOTHER'S MAIDEN NAME First Middle Last CLARA - - CAMPBELL		13e. STREET AND NUMBER 213 NANTICOTE ROAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. 123 09 59 30		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) KLEBSIELLA BRONCHOPNEUMONIA TOX DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 497X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) POST TRAUMATIC ENCEPHALOPATHY DUE TO GUN SHOT WOUND HEAD, OLD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from SEPT 4 , 19 68 , to SEPT 9 , 19 68 , that we last saw the deceased alive on SEPT 9 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, we (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. D. Talbert MD				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/9/68	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/12/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Joseph N. Zannino		ADDRESS 257 S. Conkling St. Baltimore, Md		25a. REC'D BY REGISTRAR SEP 11 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12609

CERTIFICATE OF DEATH

12619

1. DECEASED-NAME (Type or print) Warren Kelley			2a. DATE OF DEATH Month September Day 19 Year 1968			2b. HOUR 2 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 5, 1889		6. AGE (n years lost birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6700 Riverdrive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sign Painter-Donnelly		12b. KIND OF BUSINESS OR INDUSTRY Outdoor Adv.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 6700 Riverdrive Road							
14. FATHER'S NAME First John Middle J. Last Kelley			15. MOTHER'S MAIDEN NAME First Mildred Middle Holston				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-07-1536		17. INFORMANT (Wife) Mrs. Mary T. Kelley, 6700 Riverdrive, Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 185x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 177x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 7-17 , 19 68 , that (I) (we) last saw the deceased alive on 9-19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John V. Conway				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/20/68	
22d. PHYSICIAN'S NAME (Type) John V. Conway		M.D.		22e. ADDRESS 914 "D" Street, Sparrows Point, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
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12610		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12620	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR
AGNES		A.	KELLY		Sept. 6, 1968		1:55 PM
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
female	caucasian		Jan. 26, 1913		55 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Balto, Md.	USA				Baltimore		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Parkville		8604 David Ave.		Sales Clerk, Sears & Roebuck, ret			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Balto.		Parkville		8604 David Ave.	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
Martin		J	Kelly		Catherine		Banahart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No.		216-07-2231		Mrs Martin Northern		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>							5 minutes
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Angiostenosis arteriosclerosis (CVD)</u>							16 years
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1968</u> to <u>Sept 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 6, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Seymour H. Rubin</u>						9/7/68	
22d. PHYSICIAN'S NAME (Type)		Dr. Seymour H. Rubin		22e. ADDRESS		5415 Park Heights Ave, Balto, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		9/10/68		New Cathedral		Baltimore, Maryland	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
leonard J. Ruck, Inc.-Balto, Md.-14				SEP 9 1968		J Charles Judge	

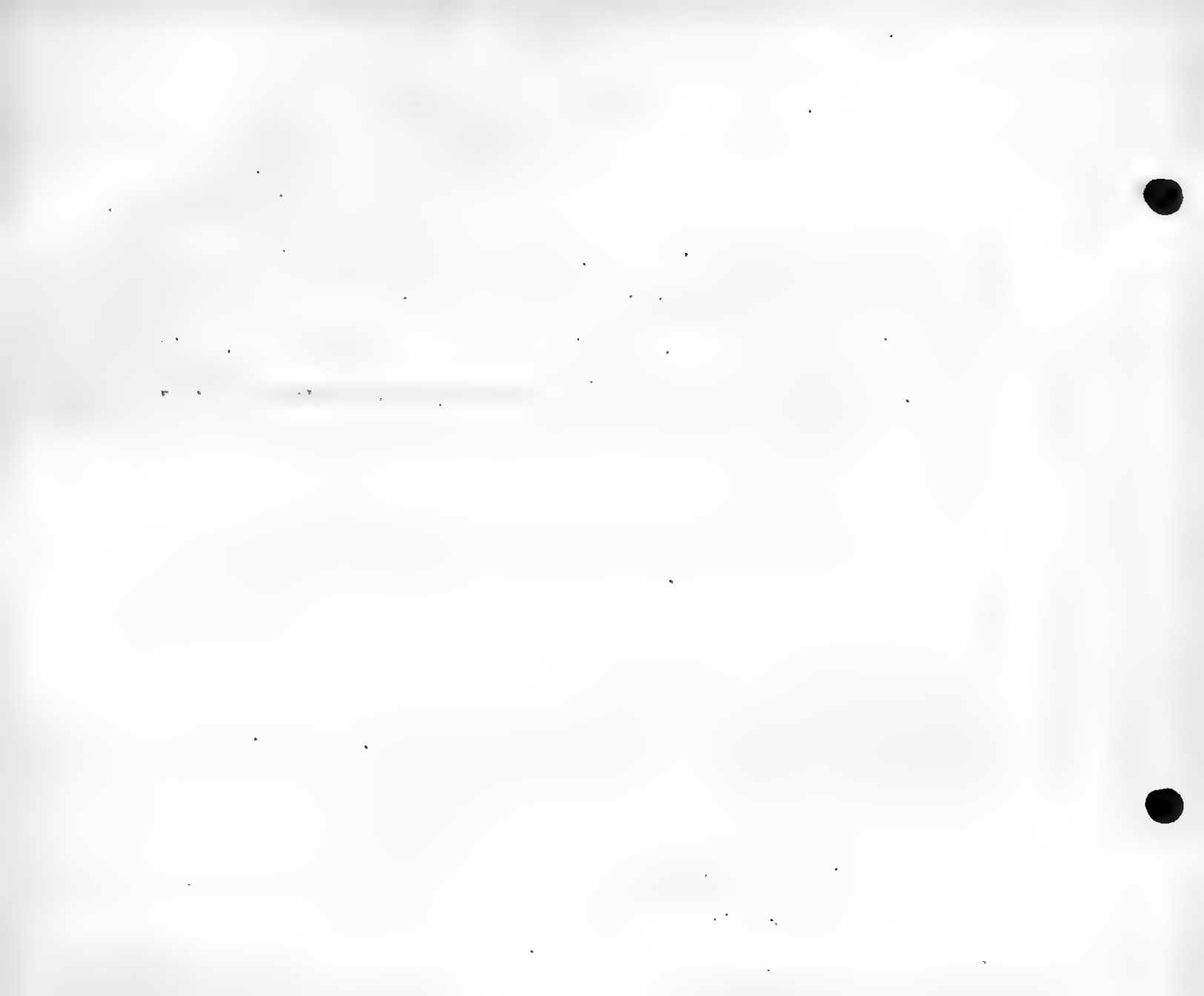


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VR 1515
30M REV. 1-48

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last BENEDICT JOSEPH KEMMER						2a. DATE OF DEATH Month Day Year SEPT 9 1968			2b. HOUR 11 P M		
3 SEX M.		4. RACE W.		5. DATE OF BIRTH 5-12-34		6. AGE (in years last birthday) 34 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md					
10. CITY OR TOWN OF DEATH Mt. Wilson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LONGHORN MAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY HANOVER		13c. CITY OR TOWN MT WILSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1329 WILSON ST. S.	
14. FATHER'S NAME First Middle Last JOHN KEMMER				15. MOTHER'S MAIDEN NAME First Middle Last ANNA M. ZIPP							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO 21-14-7812		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAK ADVANCED PULMONARY TUBERCULOSIS											
DUE TO, OR AS A CONSEQUENCE OF (b) 01112											
DUE TO, OR AS A CONSEQUENCE OF (c) 01112											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 0021 CHRONIC ALCOHOLISM											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from AUG. 20, 1968 , to SEPT. 9, 1968 , that (I) (we) last saw the deceased alive on SEPT. 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9-9-68			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/13/68		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				23d. LOCATION (City or Town) (County) (State) Ann Arundel, Md.			
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.						ADDRESS 1501 E. Fort Avenue		25a. REC'D BY REGISTRAR SEP 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
12612		12622							
DECEASED NAME (Type or Print)		First LEROY		Middle A.		Last KENTON, SR		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1968/09/23	
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 5/27/08	6 AGE (in years) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 1968/09/23	2b HOUR 10 AM
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore, Md			
10 CITY OR TOWN OF DEATH BALTO., Maryland		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b KIND OF BUSINESS OR INDUSTRY WAREHOUSE			
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) STATE MD.		13b COUNTY BALTO.		13c CITY OR TOWN TOWSON		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 408 RAILROAD AVE.	
14 FATHER'S NAME LEROY		First Middle Last KENTON		15 MOTHER'S MAIDEN NAME MARY JANE ?		First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes give year or dates of service)		16b SOCIAL SECURITY NO 320-03-5822		17 INFORMANT ELIZABETH KENTON		ADDRESS TOWSON 408 RAILROAD AVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burn of 8.5% of Body</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Surface - Shock</u> DUE TO OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fell asleep Smoking Burned 8.5%</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> Body		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year 9/20/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell asleep Smoking</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <u>Home</u>		21f. LOCATION Street or RFD No (City or town) County State <u>Railroad Ave Lutherville Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		22b. DATE SIGNED 9/23/68		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE 9/27/68		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		23d. LOCATION (City or town) (County) (State) <u>Towson, Balto. Co. Md</u>			
24. FUNERAL DIRECTOR Chairman Funeral Home		ADDRESS 1701 Mc Culloch St Balto. Md.		25a. REC'D BY REGISTRAR DATE SEP 25 1968		25b. REGISTRAR'S SIGNATURE y Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

12613 Sarah												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												12623											
1 DECEASED NAME (Type or print) Sarah A. Kernan												2a. DATE OF DEATH Month 9 Day 13 Year 1968												2b. HOUR M											
3 SEX Female				4 RACE White				5 DATE OF BIRTH January 23, 1889				6 AGE (In years last birthday) 79 YRS				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN															
7a BIRTHPLACE (State or foreign country) Baltimore				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md																							
10. CITY OR TOWN OF DEATH Baltimore, Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Home				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper				12b KIND OF BUSINESS OR INDUSTRY																							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b COUNTY Baltimore				13c CITY OR TOWN Baltimore				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET AND NUMBER 5429 Whitlock Rd.																			
14. FATHER'S NAME First Middle Last John Kernan				15 MOTHER'S MAIDEN NAME First Middle Last Sara Caton				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown				16b SOCIAL SECURITY NO 216-10-4250				17 INFORMANT Edward A. Kernan, 4735 Dartford Rd. Balto, Md.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A.S.C.V.D. 4129												year																							
DUE TO, OR AS A CONSEQUENCE OF (b)																																			
DUE TO, OR AS A CONSEQUENCE OF (c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 422																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No				City or Town				County				State															
22a. I certify that (I) (this hospital) attended the deceased from 9/11, 1968, to 9/13, 1968, that (I) (we) last saw the deceased alive on 9/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE J. C. Pournon												DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED																			
22d. PHYSICIAN'S NAME (Type) J. C. Pournon												22e. ADDRESS 3325 Trenchard																							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE Sept. 16, 1968				23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (City or Town) Baltimore, Maryland (County) (State)																							
24. FUNERAL DIRECTOR G. Truman Schwab, 5151 Balto. Natl. Pike, Balto, Md.												25a. REC'D BY REGISTRAR SEP 18 1968				25b. REGISTRAR'S SIGNATURE																			

12614

CERTIFICATE OF DEATH

12621

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month		Day	Year	2b HOUR a. M.		
ROBERT		HOWARD	KING	SEPTEMBER	8	1968	5:05	a. M.			
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
MALE	NEGRO		MAY 24, 1923		45 YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
VIRGINIA		U.S.A.				BALTIMORE		Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VETERANS ADMINISTRATION HOSP.		CHAUFFEUR							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
BALTIMORE				BALTIMORE				306 EAST LAFAYETTE AVE.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
SAM WILLIAMS					MARY KING						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
YES		WW-11		216 18 0114		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA								DAYS			
150X DUE TO, OR AS A CONSEQUENCE OF TRACHEO-ESOPHAGEAL FISTULA								MONTHS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF ESOPHAGUS								MONTHS			
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION		Street or R.F.D. No		City or Town		County	State
22a. I certify that (X) (this hospital) attended the deceased from May 9, 1968, to Sept. 8, 1968, that (X) (we) last saw the deceased alive on Sept. 8, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (d.d) (do not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED					
MARCO J. QUIROS, M. D.						9 8 68					
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS		22f ADDRESS		22g ADDRESS					
		VET. ADM. HOSP., Ft. Howard, MD.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9-12-68		BALTIMORE NATIONAL CEMETERY		BALTIMORE				MARYLAND	
24. FUNERAL DIRECTOR		24a ADDRESS		24b RECD BY REGISTRAR		24c REGISTRAR'S SIGNATURE					
Marshall W. Jones, Jr.		Marshall Jones 1735 Harford Rd. Baltimore, Md.		SEP 10 1968		J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

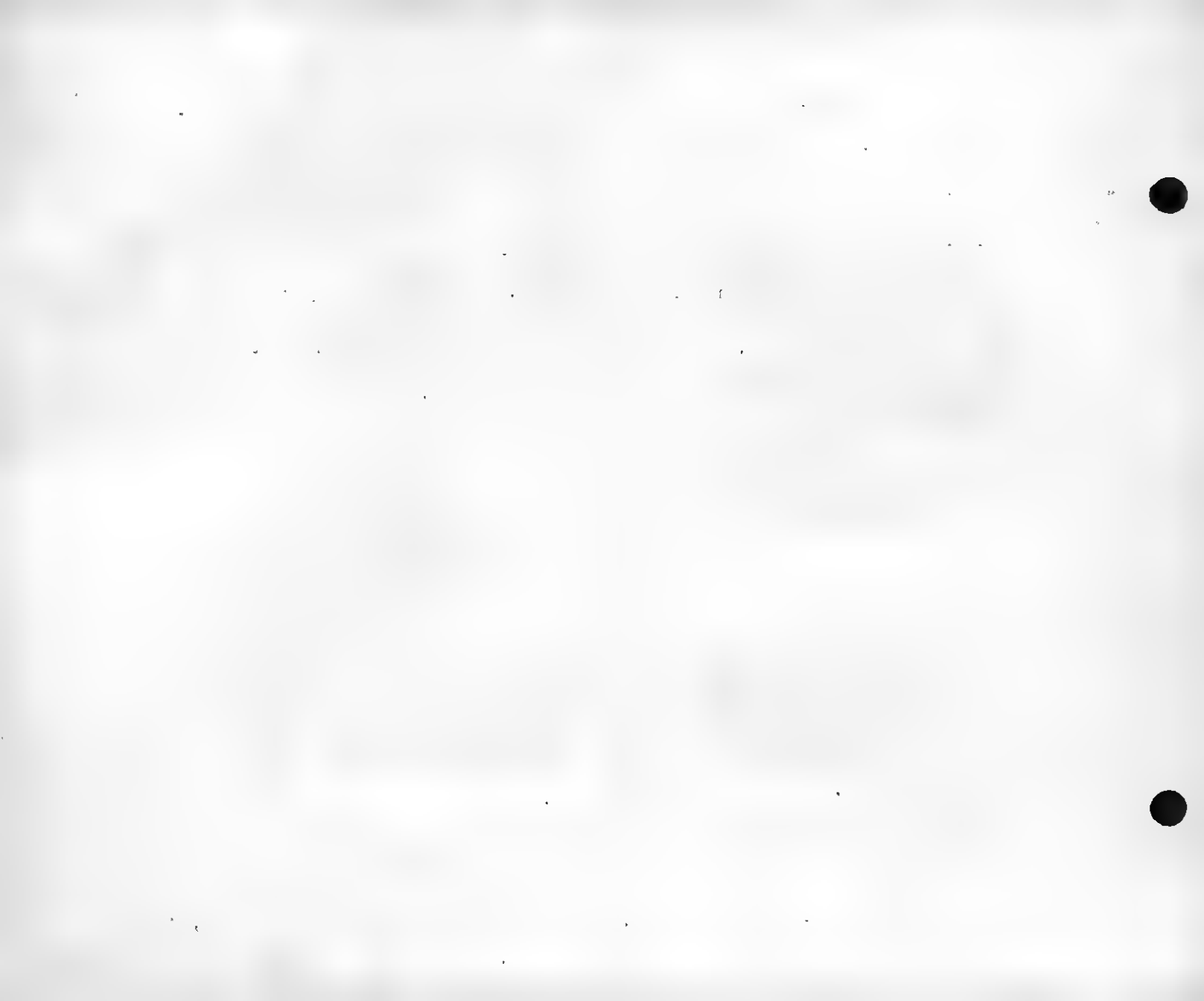
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12615 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12625	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Stanley Arthur Kirk						DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			9/2 1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7. UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	7-11-1929	39 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		1968/10/16	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		USA				Baltimore Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			2004 Thayer Terrace			Attendant - Service Station					
13a. USLA. RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE		13b. COUNTRY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Baltimore		Balto.				2004 Thayer Terrace			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Arthur S. Kirk				Catherine Stedding							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No						Joseph B. Kirk-2005 Thayer Terrace # 7					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senary Blay Disease</u>										3mo.	
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
+2											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			9-2-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		9-5-68		Mt. Olive Cemetery			Randallstown, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ellsworth Armacost -4600 Liberty Hgts. Ave						DATE SEP 3 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12616

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12626

Item #23d, Film 4425 10/2/68 km

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) George J. Klein		First Middle Last		2a DATE OF DEATH Month / Day / Year 9 / 18 / 68		2b HOUR 10 AM	
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MAR. 10, 1893		6 AGE (In years lost birthday) 75 YRS	
7a BIRTHPLACE (State or foreign country) Balto. Cnty		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3 MIAD Avenue		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HECKSTER		12b KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a USLA RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME ADAM		First Middle Last		15 MOTHER'S MAIDEN NAME MARGARET Diegert		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) NO		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. 218-32-0864		17 INFORMANT George A Klein	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerosis, Coronary Artery Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknt	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema, Chronic Nephritis							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 8-16, 1964 , to 9-18, 1968 , that (I) (we) last saw the deceased alive on 9-14-68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE John C. Hyle		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 9-19-68	
22d PHYSICIAN'S NAME (Type) JOHN C. Hyle MD		22e ADDRESS 2527 Belmar Rd Baltimore 31236 Md					
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE 9/21/68		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville, Balto., Md.	
24 FUNERAL DIRECTOR LASSAND FUNERAL Home		ADDRESS 7451 Belair Rd. BALTO. MD.		25a RECEIVED BY REGISTRAR SEP 23 1968		25b REGISTRAR'S SIGNATURE John Charles Judge	



12617

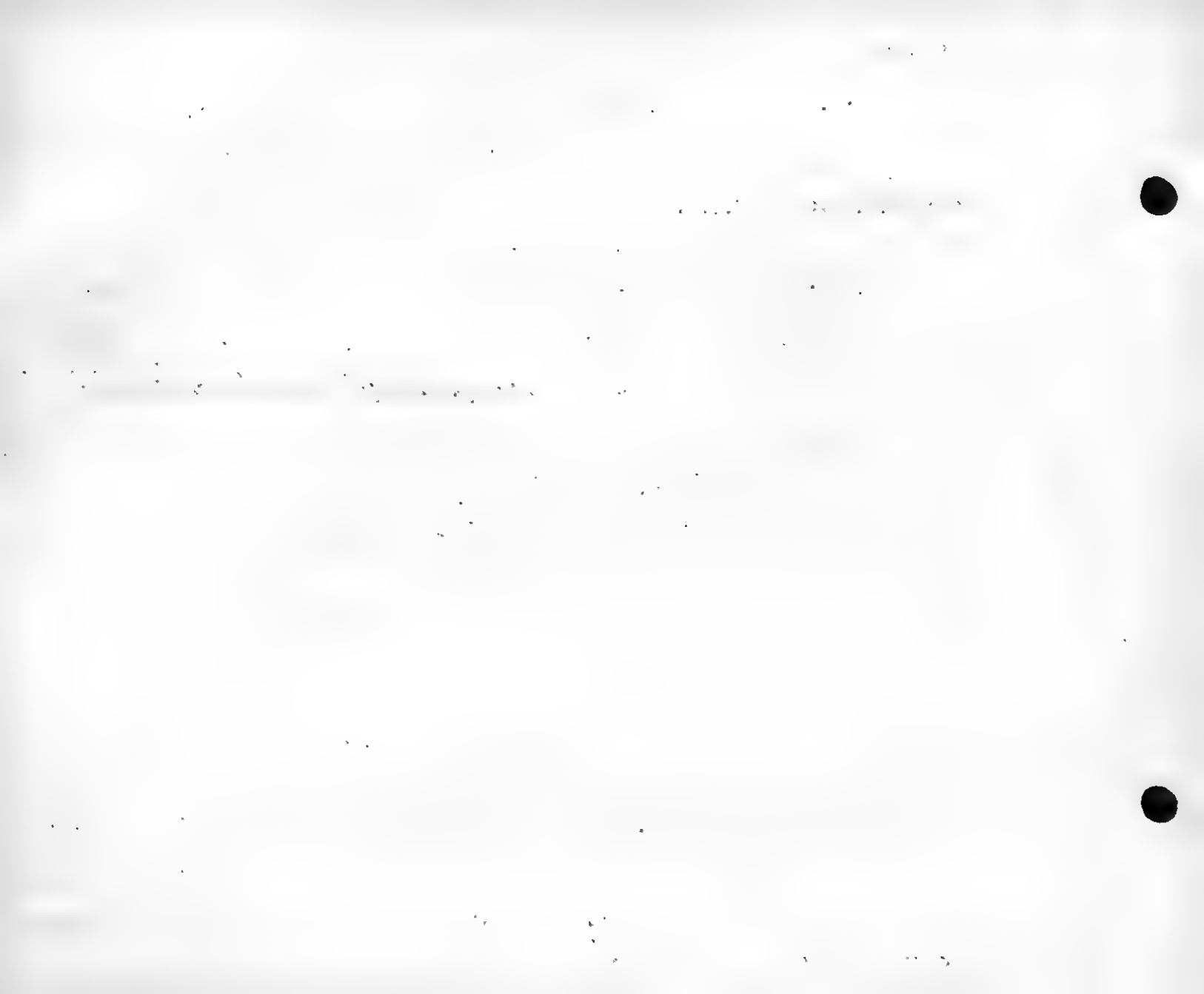
CERTIFICATE OF DEATH

12627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) ANNETTE DELPHINE KNIGHT			2a. DATE OF DEATH Month SEPTEMBER Day 5th Year 1968			2b. HOUR 12:20 AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH NOVEMBER 17th, 1965		6 AGE (In years last birthday) 2 YRS		IF UNDER 1 YEAR MONTHS 2 DAYS 2 HOURS 2 MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE COUNTY			
10 CITY OR TOWN OF DEATH OWINGS MILLS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROSEWOOD STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 13719 Marianna Drive			
14 FATHER'S NAME First GEORGE Middle - Last KNIGHT			15. MOTHER'S MAIDEN NAME First VIVIAN Middle Lee Last KNIGHT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO none		17. INFORMANT Dr. Vivian Knight - 13719 Marianna Drive, Rockville, Md. Robert Wood, Rosewood State Hospital, Baltimore, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Porencephaly on right cong. DUE TO, OR AS A CONSEQUENCE OF (c) Convulsive disorder								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since birth	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from 8/21 , 19 67 , to 9/5 , 19 68 , that (we) last saw the deceased alive on 9-4 , 19 68 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arnold Kolta		22c. DATE SIGNED 9-5-68		22d. PHYSICIAN'S NAME (Type) ARNOLD KOLTA MD		22e. ADDRESS Rosewood State Hosp., Owings Mills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-6-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Smithland Maryland			
24. FUNERAL DIRECTOR Walter Lee Murphy		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

12618

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN lb Towson		2. USUAL RESIDENCE (Where deceased lived f institution. Residence before admission) a. STATE MD b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS Route 1 Box 208 6708 N. Charles Street	
3. NAME OF DECEASED (Type or print) First Middle Last George Albert Koerber		4. DATE OF DEATH Month Day Year 9 15 19 68	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27 1891
9. AGE (In years) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 19 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resident MAN		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Koerber		14. MOTHER'S MAIDEN NAME Amelia K Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) NO		16. SOCIAL SECURITY NO 212-03-6728	
17. INFORMANT WALTER A Koerber		Address 816 Pleasant Pl	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 9040 (b) Fracture right humerus DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 9/14 19 68		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home		20f. CITY OR TOWN (County) (State) White Hall BALTO MD	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county)	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/19/1968	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City or town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Chas. F. Evans		ADDRESS 8802 Hartford Rd	
25a. REC'D BY REGISTRAR SEP 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

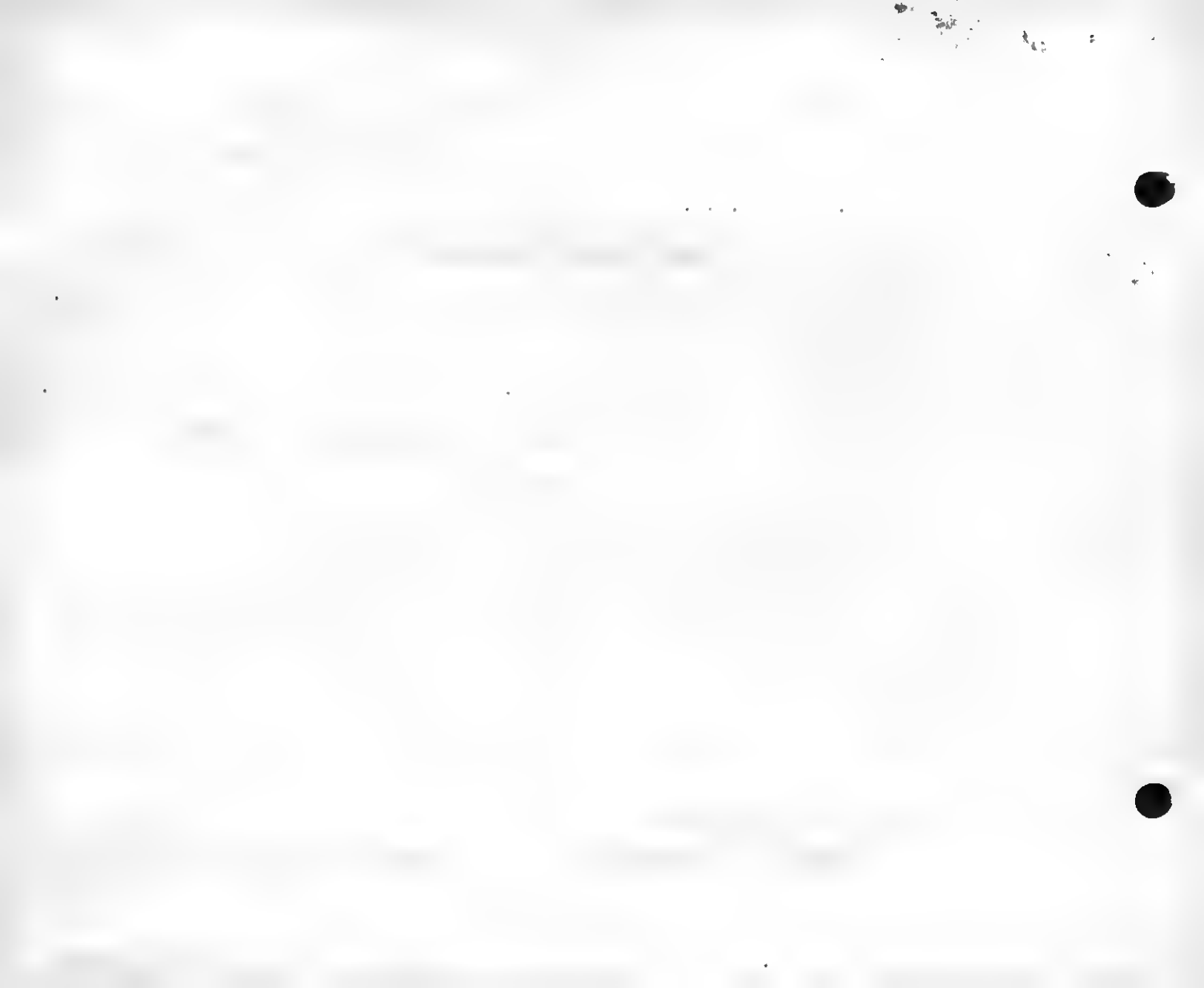
12619

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12629

1. DECEASED-NAME (Type or print) Harry S Kolker			2a. DATE OF DEATH Month Sept. Day 15 Year 1968		2b. HOUR 1:30 P M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10-22-05		6. AGE (in years lost birthday) 62 YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto County General Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CUTTER	12b. KIND OF BUSINESS OR INDUSTRY CLOTHING		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND	3b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3524 LANGREHR ROAD, APT. 2C	
14. FATHER'S NAME First LOUIS Middle KOLKER Last ROSE	15. MOTHER'S MAIDEN NAME First ROSE Middle ? Last ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 219-01-2249	17. INFORMANT Address MRS. IRENE KOLKER, 3524 LANGREHR ROAD, APT. 2C			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardium Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost ASHD DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4109					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 9-8-68 , 19 68 , to 9-15 , 19 68 , that (I) (we) last saw the deceased alive on Sept 15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Boon Vanasin		DEGREE ATTENDING PHYS <input type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED Sept 15, 68		
22d. PHYSICIAN'S NAME (Type) BOON VANASIN		22e. ADDRESS Balto County General Hosp.			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE 9-16-68	23c. NAME OF CEMETERY OR CREMATORY JEHUDA AMACAHBY	23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR SEP 17 1968	25b. REGISTRAR'S SIGNATURE J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
12620 CERTIFICATE OF DEATH 12330													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
WALTER							KORAS		Month 9 Day 17 Year 68			1:00AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years ast birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		4/2/92				76 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
POLAND		U.S.A.				BALTIMORE COUNTY,						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
FORT HOWARD		VET. ADM. HOSPITAL		STORE OWNER		CONFECTIONER							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER				
MARYLAND					BALTIMORE				2409 Falt Avenue				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
MARTIN							KOROS		MARIAN			(UNKNOWN)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address					
YES			WW I		217 54 46 94			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> 481X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4100													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (H) (this hospital) attended the deceased from 9/16/68, 19__, to 9/17/68, 19__, that (H) (we) last saw the deceased alive on 9/17/68, 19__, and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Walter Avni Orer M.D.								DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/17/68	
22d. PHYSICIAN'S NAME (Type)						INFAN A. ORER, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL		9/20/68		ST. STANISLAUS CEMETERY			BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
				KACZOROWSKI FUNERAL HOME		SEP 23 1968		J. Charles Judge					
				2525 Fleet Street, Baltimore, Maryland									



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12621

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12621

1 DECEASED NAME (Type or Print)		First WALTER H.		Middle KRAFT		Last		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 9 Day 20 Year 1968		2b HOUR M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8-19-1920	6 AGE (In years last birthday) 48 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 9- Day 20- Year 1968		2d HOUR M	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Lansdowne		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2959 Freeway		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cab Driver		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Lansdowne		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2959 Freeway			
14 FATHER'S NAME First Middle Last George H. Kraft				15 MOTHER'S MAIDEN NAME First Middle Last Helen E. Kraft							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES YES		16b SOCIAL SECURITY NO (If yes give war or dates of service) WW II		17. INFORMANT Mrs. Katherine Kraft		ADDRESS 2959 Freeway 21227					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cor. Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 1 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) High tension Cor. Artery Disease											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE J. Nelson McKay, M.D.		EXAMINER'S NAME (Type) 014 Edmondson Ave., 21228		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 9/20/68	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-24-1968		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland		25a REC'D BY REGISTRAR DATE SEP 23 1968			
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229		25b. REGISTRAR'S SIGNATURE J. Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
304 REV

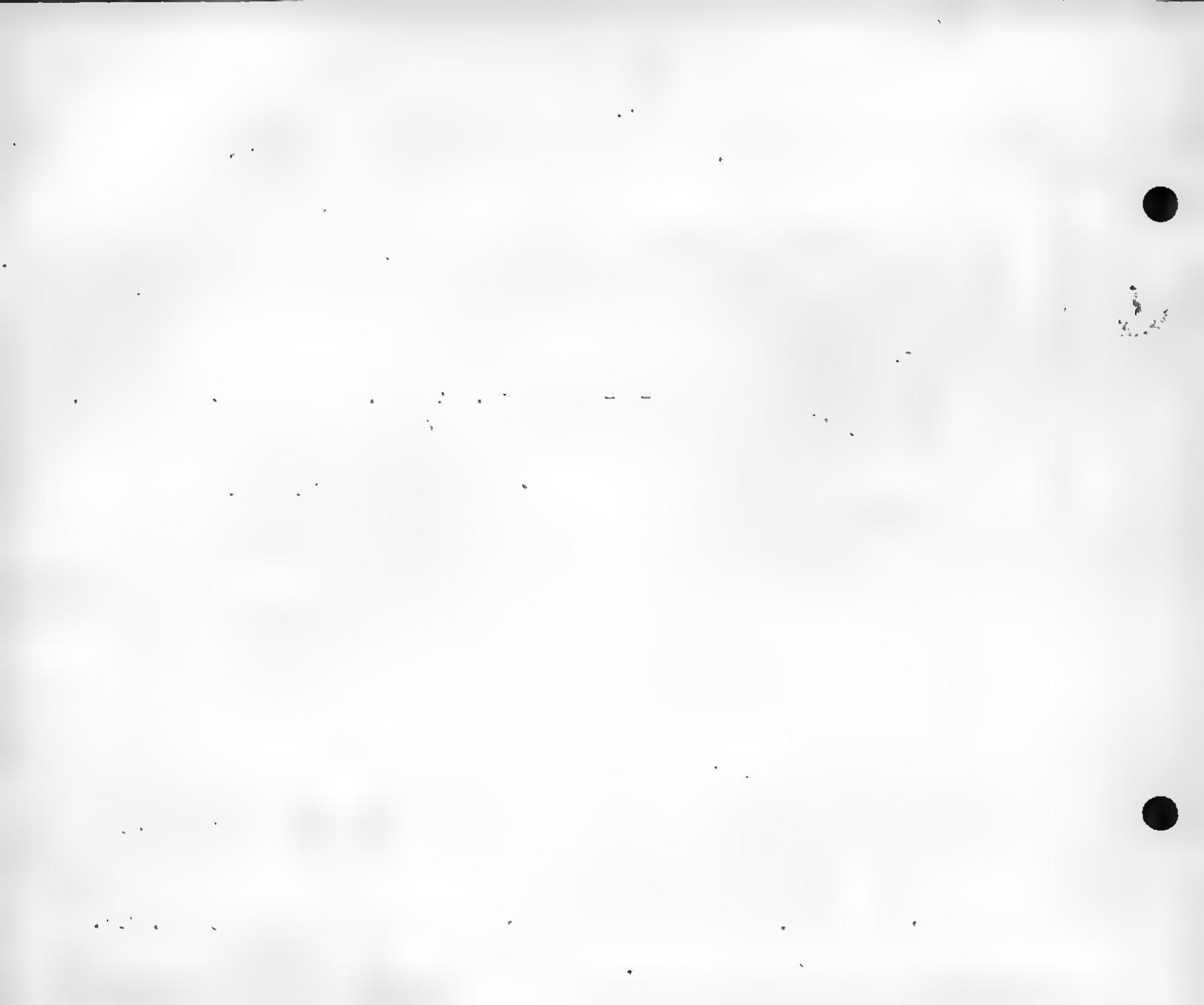
12622		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12632	
1 DECEASED-NAME (Type or print) MARGARET			2a. DATE OF DEATH 9 Month 18 Day 68 Year		2b. HOUR 24 M
3 SEX F	4. RACE W	5 DATE OF BIRTH 9-28-1893	6 AGE (In years lost birthday) 75 YRS	7 UNDER YEAR MONTHS	8 UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) BALTO. Md	7b CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTO.		
10 CITY OR TOWN OF DEATH CATONSVILLE	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor Conv.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE Md	13b COUNTY -	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3713 E. Lombard Street	
14 FATHER'S NAME First George Middle C. Last KRIEG	15 MOTHER'S MAIDEN NAME First ANNA Middle MARGARET Last MADER	16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16b SOCIAL SECURITY NO.		17 INFORMANT Hospital Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					1 month
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
331X					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1 Jan , 19 66 , to 18 Apr , 19 68 , that (I) (we) last saw the deceased alive on 17 April 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE William Goodman		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 18 April 68		
22d PHYSICIAN'S NAME (Type) William Goodman, MD		22e ADDRESS 1354 Sulfur Spring Rd.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 9/20/68	23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEM	23d LOCATION (City or Town) BALTO.	(County) Md	(State)
24 FUNERAL DIRECTOR E. Mac Nab		ADDRESS 301 Frederick Rd Balto 28 Md	25a REC'D BY REGISTRAR SEP 23 1968	25b REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12623		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12633	
Item #8		Filer #G404		9/23/68 vmp	
1. DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH Month Day Year	
Adolph R. Krupske				September 13, 1968	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR
Male	White	6-23-92		10 YRS.	MONTHS DAYS
7b. BIRTHPLACE (State or foreign country)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
	USA		Baltimore, Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. JSOA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Randallstown	Harro Co Gen Hosp		Stone and Brick Mason		Masonry Bus.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INS DE CITY LIMITS?	13e. STREET AND NUMBER	
Ind.	Baltimore	Randallstown	NO <input checked="" type="checkbox"/>	Marriottsville Rd.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
Edward Krupske		Augusta Hopp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	17. INFORMANT Address		
NO		333-05-6251A	Mrs. Clare K. Tomm Marriottsville Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ 431.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Generalize A. Schwesio + Hyertenne Disease - 10 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9-13, 1968, to 9-13, 1968, that (I) (we) last saw the deceased alive on 9-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Angelita A. Tappin		DEGREE ATTENDING PHYS.		22c. DATE SIGNED 9-13-68	
22d. PHYSICIAN'S NAME (Type) ANGELITA TAPPIN		22e. ADDRESS Baltimore County General Hosp.			
23a. BURIAL CREMATION, REMOVAL, ETC. Burial		23b. DATE Sept. 17, 68		23c. NAME OF CEMETERY OR CREMATORY Concordia Cem.	
				23d. LOCATION (City or Town) (County) (State) Chicago Cook Co. Ill.	
24. FUNERAL DIRECTOR Loring Byers		ADDRESS 8729 Liberty Rd. Randallstown		25a. REC'D BY REGISTRAR DATE SEP 16 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 11-68

12624

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

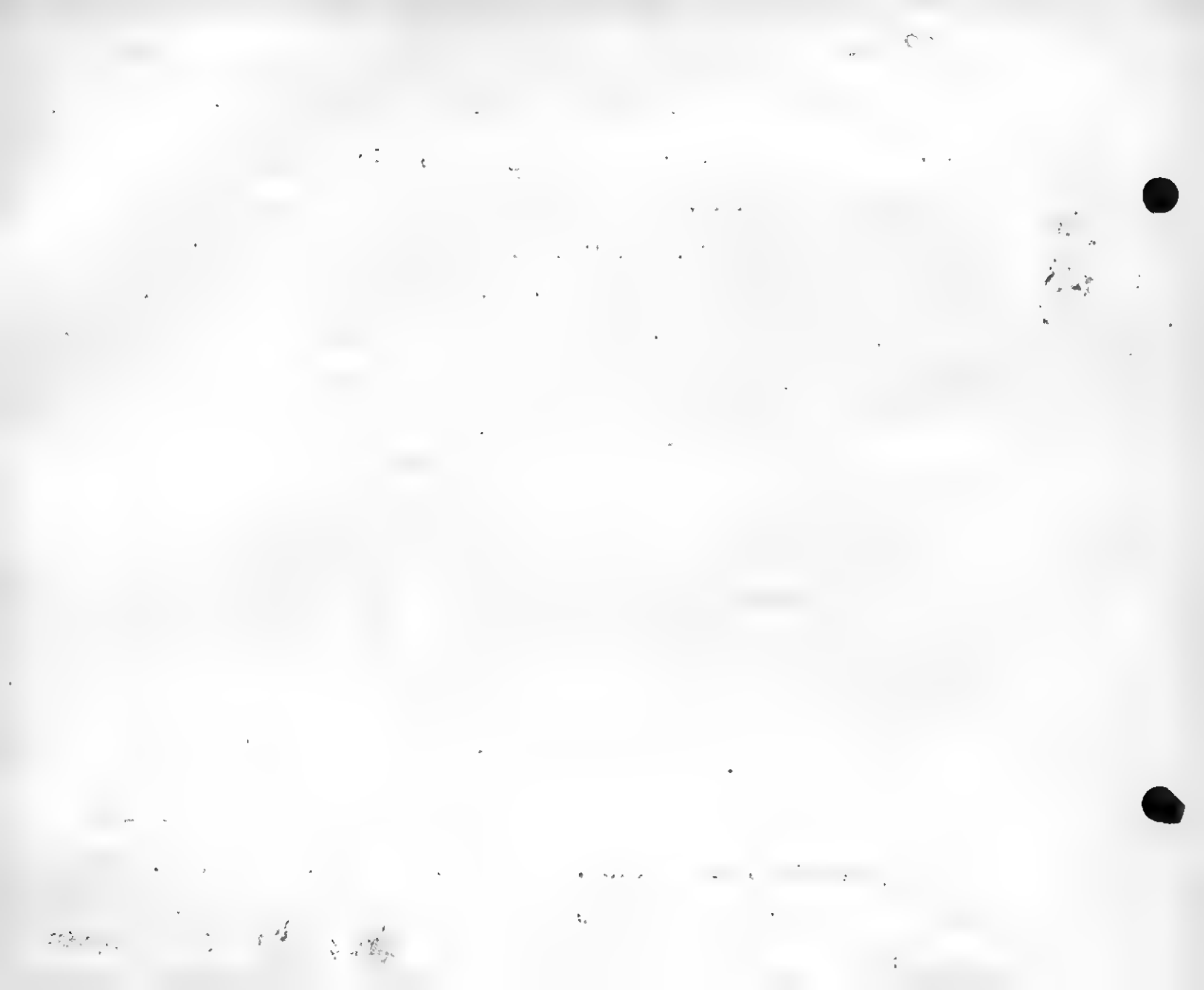
CERTIFICATE OF DEATH

12624.1

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
JOHN FRANCIS LARKIN						Month	Day	Year	P	
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)	
MALE			WHITE			MAY 29, 1926			42 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
MARYLAND			U.S.A.						BALTIMORE Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			ST. JOSEPH'S HOSPITAL			POST OFFICE EMPLOYEE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
Maryland						BALTIMORE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
									13e. STREET AND NUMBER	
									3030 EAST AVE.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle
Thomas J Larkin						Margaret Spurrier				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
Yes			215-22-1313			Mildred M Larkin			Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal sarcomatosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>synovial sarcoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 6</u> , 19 <u>68</u> , to <u>SEPT 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>SEPT 20</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Christina Feliciano</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>9-21-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Christina Feliciano, M.D.</u>						22e. ADDRESS <u>7520 YORK RD. TOWSON, MD. 21204</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			9/24/68			Parkwood			Baltimore, Maryland	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc Baltimore, Md						DATE <u>SEP 24 1968</u>			<u>John J. Jones</u>	

MEDICAL CERTIFICATION

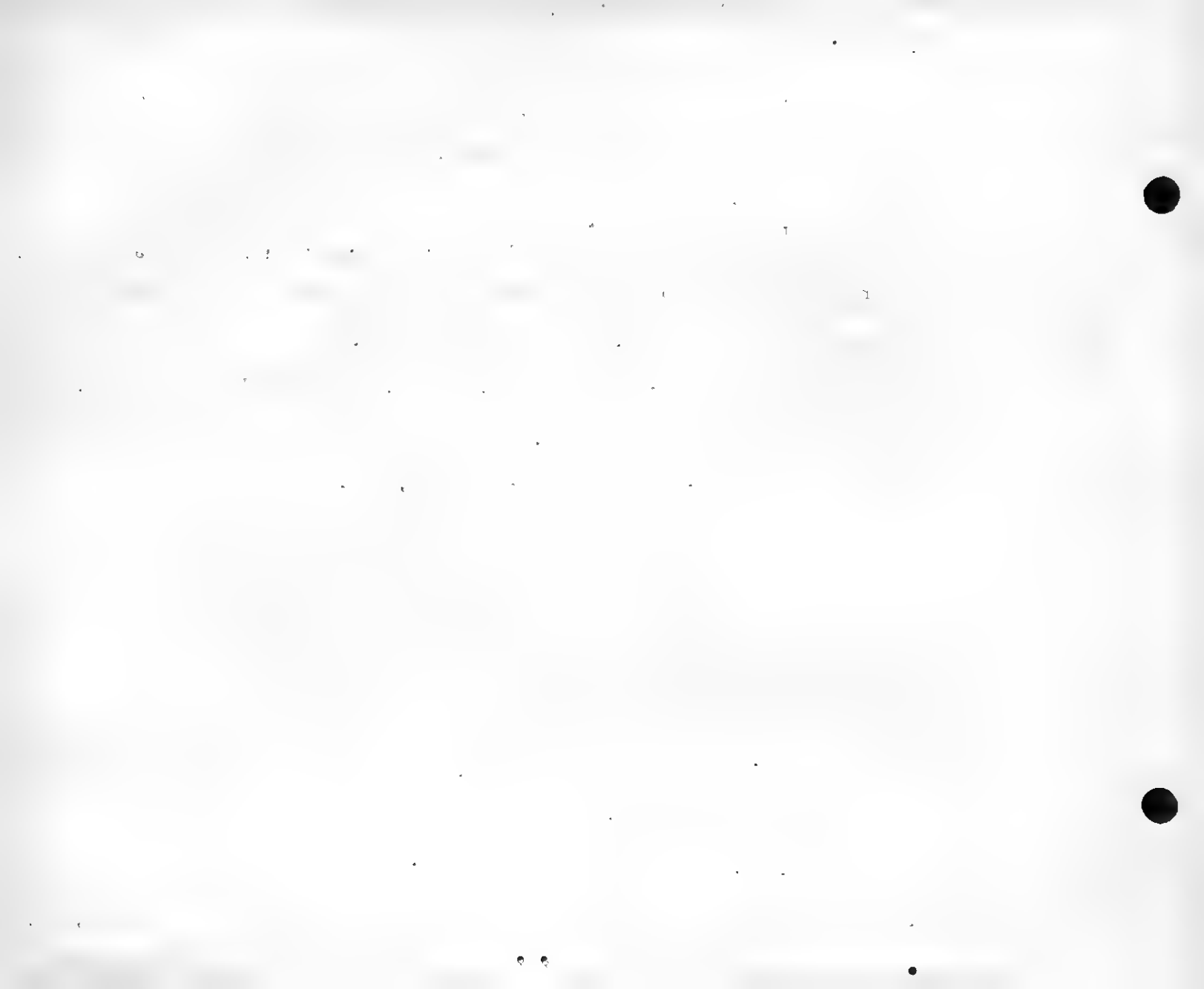
X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
12625 CERTIFICATE OF DEATH 12635															
1. DECEASED-NAME (Type or print)			First RAYMOND		Middle C.		Last LARSEN		2a. DATE OF DEATH			2b. HOUR			
									9 Month 3 Day 68 Year			8:28A M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (n years lost birthday)			7. IF UNDER 1 YEAR MONTHS		7. IF UNDER 24 HRS. HOURS MIN.	
Male			White			June 28, 1904			64 YRS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Iowa			U.S.A.						Baltimore, Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Towson Baltimore, Md.			Greater Baltimore Med. Cen.			Logistics Sup.			Unitec Ind.						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY, N.Y. 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Maryland			Baltimore			Towson			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1027 Marleigh Cir.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Louis Larsen			Anna Boos												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (if yes, give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address						
No			483-07-5777			Mrs. Leta J. Larsen			1027 Marleigh Cir.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 185X Pulmonary embolism															
DUE TO, OR AS A CONSEQUENCE OF															
(b) Metastatic carcinoma of prostate to liver															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
111X															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 8/2/1968, to 9/3/1968, that (I) (we) last saw the deceased alive on 9/3/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Charles C. Brown, M.D.						22c. DATE SIGNED 9/3/68			22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.						
22e. ADDRESS Greater Baltimore Medical Center															
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			9/6/68			Dulaney Valley Cemetery			Cockeysville Baltimore, Md.						
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Wm. Cook-Brooks Towson 1050 York Rd. 21204						DATE SEP 5 1968			Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) Dolores E LATTANZI			2a DATE KNOWN OF DEATH ESTIMATED Sept 25 1968			2b HOUR 5:10 AM			
3 SEX Female	4 RACE White	5 DATE OF BIRTH 12/4/14	6 AGE (in years last birthday) 53 YRS	7 UNDER YEAR MONTHS 53	8 UNDER 24 HRS DAYS 53	9 UNDER 24 HRS HOURS 53	10 UNDER 24 HRS MIN 53	2c DATE PRONOUNCED DEAD Month September Day 25 Year 1968	2d HOUR 5:10 AM
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZENSHIP OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,			
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY L.M.I.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3134 Berkshire Rd.
14 FATHER'S NAME First Middle Last Peter J Streb			15. MOTHER'S MAIDEN NAME First Middle Last Mary A Seccombe						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-09-5664		17 INFORMANT ADDRESS Richard E Lattanzi 5630 Arnhem Rd Balto, Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sub Dural Hematoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 Days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION 12 September 68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Sub Dural Hematoma				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year 12 September 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell Down Stairs in Home				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No City or Town County State 3134 Berkshire Rd Baltimore, Md				
22a. I certify that I took charge of the remains described above, heard an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles F. O'Donnell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9/25/68			
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE 9/28/68		23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc, Baltimore, Maryland					25a REC'D BY REGISTRAR SEP 26 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 116
30M REV 1-68

12627

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12637

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
ANNIE			M.	LAUMANN	Sept. 10 1968				
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS HOURS MIN		
Female	White		July 23, 1880		88 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		U. S. A.				Baltimore			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Catonsville		1000 Kent Avenue		Housewife					
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Catonsville				1000 Kent Avenue 21228	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Benjamin Holtzner					Mary Deerbach				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address	
				None		Ethel L. Walmer		1000 Kent Ave. Catonsville	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4129		Bronchopneumonia				5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		3 months			
		Congestive Heart Failure		(c)		15 years			
		Arteriosclerotic Heart Disease							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1900		Chronic Pyelonephritis + Renal Calculus							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 9/5 1968, to 9/10 1968, that (I) (we) last saw the deceased alive on 9/5 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE		22c. DATE SIGNED					
Dr. Max Miller		9/12/68							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f. LOCATION (City or Town) (County) (State)					
Dr. Max Miller		1047 Ingleside Ave., Balto., Md.							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		9-13-68		Crest Lawn Memorial Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE			
Howard H. Hubbard		4107 Wilkens Ave. Balto		SEP 16 1968		J. Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12628

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12628

1 DECEASED-NAME (Type or Print)		First Middle Last		2a DATE KNOWN OF DEATH		Month Day Year		2b HOUR	
ALBERT JOSEPH		Leitschuh, Jr.		MATED <input checked="" type="checkbox"/>		9 17 1968		7:15	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	8-6-48	20 YRS			Month Day Year		7:15	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U. S.				Balto.		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Loch Raven		Loch Raven Res. area							
13a USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, APTS?		13e STREET AND NUMBER	
Md.		Baltimore		Towson		YES <input type="checkbox"/> NO <input type="checkbox"/>		939 Ellendale Dr.	
14 FATHER'S NAME		First Middle Last		15 MOTHER'S MAIDEN NAME		First Middle Last			
Albert J. Leitschuh				Latherine Bateman					
16a WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
Yes		215-54-4117		U. S. Navy Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the heart									
7227 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 9 ? 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)					
				Subject accidentally shot					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
				Loch Raven area		Loch Raven		Balto. Md.	
22a. I certify that I took charge of the remains described above, he died an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
<i>Edward F. Wilson</i>		Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/18/68	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		9-21-68		Dulaney Valley		Balto.		Towson Md	
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Harry Litcke				Howard Co. Funeral Home Ellicott City Md		SEP 20 1968		<i>Charles Judge</i>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers ~~pages~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 12629 MARYLAND STATE DEPARTMENT OF HEALTH 12639 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or print) Anna				First C. Middle Letmate Last				2a DATE OF DEATH Month 9 Day 3 Year 1968			2b HOUR 8:30 AM <input checked="" type="checkbox"/> PM
3 SEX Female		4 RACE White		5 DATE OF BIRTH 8/10/83			6 AGE (in years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) Balto. Md.				7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Rural Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Augsburg Home 6811 Campfield Road			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seamstress			12b KIND OF BUSINESS OR INDUSTRY Retail Store		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b COUNTY 17b		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 819 Wedgewood Road 21229	
14. FATHER'S NAME First J. Middle Frederick Last Letmate				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Gerwig Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No				16b SOCIAL SECURITY NO 220-12-9733-A		17 INFORMANT Address Anita W. Strohmer, Office Mgr. Augsburg Home					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>402X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arterio Sclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a I certify that (I) (this hospital) attended the deceased from <u>June 7</u> , 19 <u>65</u> , to <u>Sept. 3</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>6/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Earl L. Chambers M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c DATE SIGNED <u>9/3/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>						22e ADDRESS <u>4108 Liberty Hts. Ave Balto Md</u>					
23a BIRTH, CREMATION, REMOVAL, ETC.		23b. DATE <u>Sept 6 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		23d. LOCATION (City or town) (County) (State) <u>Piolettville Md</u>					
24. FUNERAL DIRECTOR <u>W. Hermann 6067 York Rd</u> ADDRESS						25a REC'D BY REGISTRAR <u>SEP 10 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12630

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12630

1. DECEASED-NAME (Type or print) Virginia Pauline Lindeman			2a. DATE OF DEATH Sept Month 15 Day 68 Year			2b. HOUR 6:45 P.M.				
3 SEX Female		4 RACE Cau.		5. DATE OF BIRTH 4/5/21		6 AGE (In years last birthday) 47 YRS.		F. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co.		Md.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1 Colony Hill Court		
14. FATHER'S NAME First Middle Last Edward G. Roberson			15. MOTHER'S MAIDEN NAME First Middle Last Susan -- Beeman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No. (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. Clyde E. Lindeman		Address 1 Colony Hill Court		City Arbutus		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) UREMIA-OLIGURIA DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CARCINOMA BLADDER								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 24 HRS. 1 YR.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 9-1 , 19 68 , to 9-15 , 19 68 , that (I) (we) last saw the deceased alive on 9-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. V. Houck, Jr.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-15-68				
22d. PHYSICIAN'S NAME (Type) R. V. Houck, Jr.		22e. ADDRESS Randallstown, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/18/68		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park,		23d. LOCATION (City or Town) Frostburg,		(County) (State) Allegany Md.		
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR SEP 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) HENRY SUMMERFIELD LITTLE			2a. DATE OF DEATH Month SEPT. Day 5 Year 68			2b. HOUR 4: A. M.							
3 SEX MALE		4. RACE WHITE		5 DATE OF BIRTH NOV. 13, 1879		6 AGE (In years last birthday) 88 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0			
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE CO. Md							
10 CITY OR TOWN OF DEATH NEAR RANDALLSTOWN			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHAPEL HILL NURSING HOME			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) FARMER			12b KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED				
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.			13b COUNTY CARROLL WESTMINSTER			13c CITY OR TOWN RED#6			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER RED#6	
14 FATHER'S NAME First EZRA J. Middle LITTLE Last GEORGIANA			15 MOTHER'S MARDEN NAME First DAVIS Middle DAVIS Last DAVIS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO 215-54-1355J1			17 INFORMANT G. IVAN LITTLE, WESTMINSTER MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Difficulty swallowing DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Artery Insufficiency										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days months years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASCVD (Coronary Arteriosclerosis) - Generalized Arteriosclerosis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6-11-1968 , to 7-5-1968 , that (I) (we) last saw the deceased alive on 7-5-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE Cesar Valle Cervero						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 9-6-68				
22d. PHYSICIAN'S NAME (Type) CEsar VALLE CAVERO						22e ADDRESS 8624 Liberty Rd							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 9/7/68			23c NAME OF CEMETERY OR CREMATORY DEER PARK CEMETERY			23d LOCATION (City or Town) (County) (State) WESTMINSTER RED#6 MD				
24 FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md						25a REC'D BY REGISTRAR SEP 9 1968			25b REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12632

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12612

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) HENRY			First CARL			Middle LOHR			Last			2a. DATE OF DEATH Month 9 Day 9 Year 1968			2b HOUR 8:05 PM		
3. SEX Male			4 RACE Caucasian			5. DATE OF BIRTH Feb. 17, 1902			6. AGE (In years lost birthday) 66 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Md.			7b CIT ZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore			12b. KIND OF BUSINESS OR INDUSTRY Ship Co.			Md		
10. CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Ship Co.								
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY A.A. Co.			13c CITY OR TOWN Paradise, Beach, A. A. Co.			13d INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER Paradise, Beach, A. A. Co.					
14. FATHER'S NAME Henry			First Lohr			Middle Johanna			Last Hoennner								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Mrs. Aviola M. Lohr Box 157 Jessup, Md. 20794			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic sarcoma 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Neurogenic sarcoma (by history) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION 11/24			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 8/14, 1968 , to 9/9, 1968 , that (I) (we) lost the deceased alive on 9/9, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE Rudiger Breitenecker, M.D.			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/10/68								
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.			22e. ADDRESS Greater Baltimore Medical Center														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 13, 1968			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			23d. LOCATION (City or Town) (County) (State) Balto, Md.								
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike			ADDRESS Balto, Md.			25a. REC'D BY REGISTRAR SEP 13 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12633												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) First Middle Last Blanche Louise Lookingbill						2a. DATE OF DEATH Month Day Year Sept. 14 1968			2b. HOUR 4:30 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 8, 1930			6. AGE (in years last birthday) 38 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto Med. Center				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Fairground Avenue				
14. FATHER'S NAME First Middle Last Daniel Allen Stull				15. MOTHER'S MAIDEN NAME First Middle Last Grace Louisa Harner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 214-28-0306		17. INFORMANT Address Mr. Francis E. Lookingbill, Taneytown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Carcinomatosis												
DUE TO, OR AS A CONSEQUENCE OF												
(b) Carcinoma of Breast												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work												
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												
21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from 9/12, 1968, to 9/14, 1968, that (I) (we) last saw the deceased alive on 9/14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John E. Adams, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>												
22c. DATE SIGNED Sept. 15, 1968												
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.												
22e. ADDRESS 6701 N. Charles Street, Towson, Md. 21204												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												
23b. DATE Sept. 17, 1968												
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Memorial Garden												
23d. LOCATION (City or Town) (County) (State) Gettysburg, Adams, Penna.												
24. FUNERAL DIRECTOR John H. Skiles ADDRESS C. O. Fisher Taneytown, Md.												
25a. REC'D BY REG. STRAR DATE SEP 17 1968												
25b. REG. STRAR'S SIGNATURE Charles Judge												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

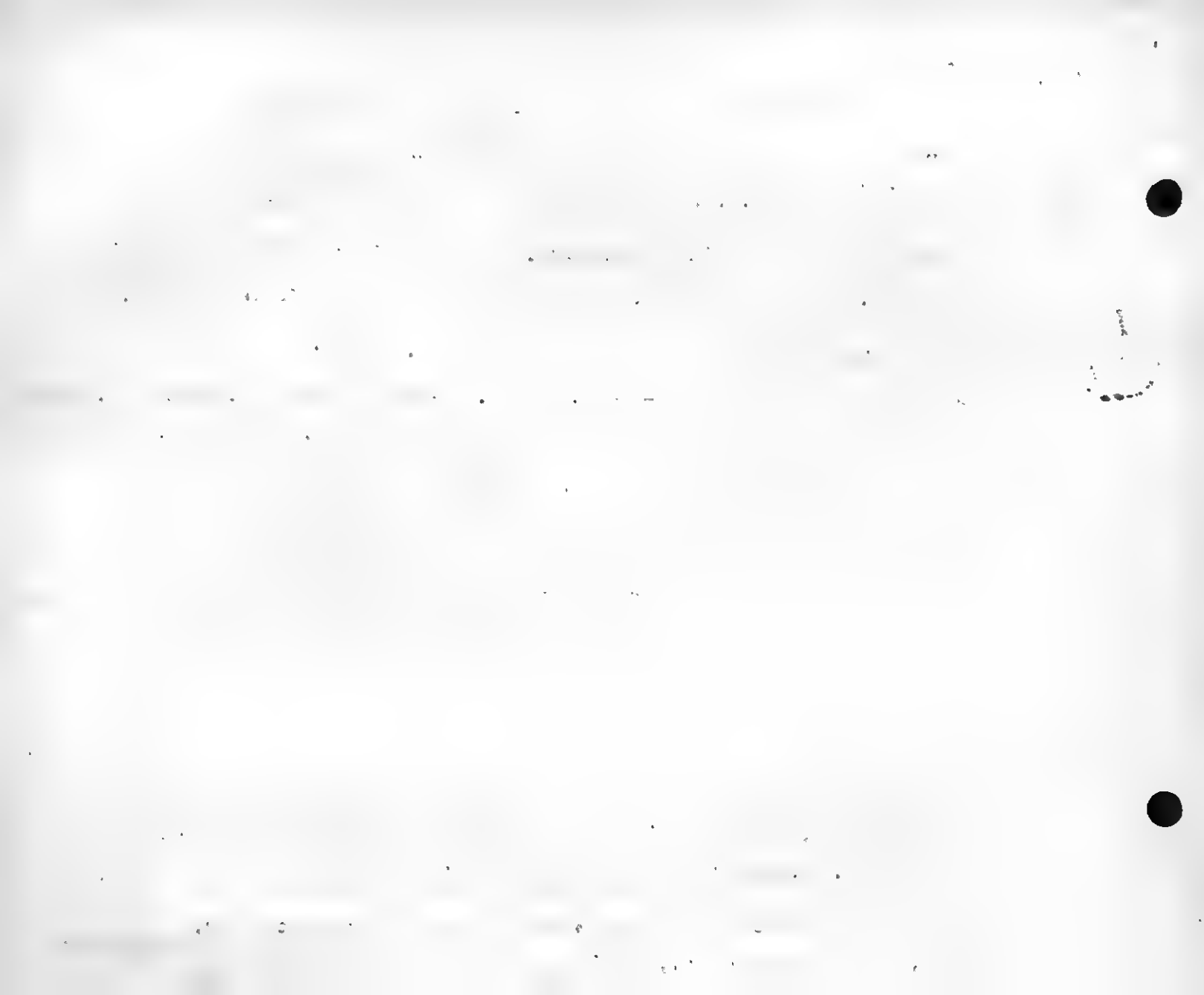
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12634

12514

1 DECEASED NAME (Type or print) Calvin			First Middle Last			2a. DATE OF DEATH 9/17/68 Month Day Year			2b. HOUR 12:45 P M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 1/18/07			6 AGE (In years last birthday) 61 YRS.			IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland Ellicott City		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore			Md		
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 214 Osborne Ave.			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Police Sergeant			12b. KIND OF BUSINESS OR INDUSTRY Police Dept.			Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 214 Osborne Ave.			
14. FATHER'S NAME First Middle Last Charles Lotz			15. MOTHER'S MAIDEN NAME First Middle Last Nora T. O'Neill									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-10-4651		17 INFORMANT Address Mrs. Gwendolyn Lotz, 214 Osborne Ave. 21228							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF A.C.U.H.D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MIN. 2 YRS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary occlusion 4 mos. previously												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased, from 4-11-60 , 19 60 , to 9-17 , 19 68 , that (I) (we) last saw the deceased alive on 8-13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. F. Schaeffer M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9-18-68		
22d. PHYSICIAN'S NAME (Type) Dr. Schaeffer		22e. ADDRESS 401 Random Road										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/20/68		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md				
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				ADDRESS		25a. SEP 20 1968		25b. Richard J. Judge				



12635

12615

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3 Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
HOWELL			MAXWELL			MACE, JR.			DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI MATED <input type="checkbox"/> 9-11 1968 MONTH DAY YEAR		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	8-25-38	30 YRS					September 11, 1968			5:30 PM
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
Baltimore			U.S.A.					BALTIMORE			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
White Marsh, Md.			Forge Road			Electrical			Vending Mach		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Baltimore						8774 Philadelphia Road		
14. FATHER'S NAME First Middle Last			15 MOTHER'S M.A.DEN NAME First Middle Last								
Howell Maxwell Mace Sr.			Alice M. Anderson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			2122			
No			229-36-1150		Mrs Marion Mace 8774 Philadelphia Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Blunt injuries of head and thorax											
841.2 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
263 X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMATE OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				4:00 PM 9-11 19 68				Pilot of single-engine aircraft which crashed and burned			
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D. No. City or Town State			
Baltimore airport				Forge Road White Marsh Baltimore Md.							
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				September 12, 1968			
Charles S. Springate, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial				9-14-1968		Gardens of Faith Cemetery		Baltimore Co. Md.			
24. FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Lassahn Funeral Home 7401 Belair Road 21236						DATE SEP 16 1968		f Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-64)
30M REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12636												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR			
First Middle Last Mary Frances Mack						Month Day Year Sept. 21, 1968			8 11:19			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Negro		June 19, 1880			88 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Virginia		U.S.A.					Baltimore Co. Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Reisterstown				77 Bond Ave				Housewife			---	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE						13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland						Baltimore				77 Bond Avenue		
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last						
Samuel Evans						Frances ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address						
no				212-16-6231		Marguerite Mack 77 Bond Ave. Reis. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										24 hrs.		
DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>Arteriosclerotic C.V. Disease with right hemiplegia</u>										11 days		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
4221												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work												
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9</u> , 19 <u>68</u> to <u>Sept. 21</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Sept. 20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>Martin E. Strobel</u>										9-23-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
Martin E. Strobel, M.D.						59 Hamover Rd. Reisterstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		Sept. 24, 1968		Mt. Pleasant Ch. Cem.		Owings Mills, Balto, Md.						
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>H. J. Schacht</u>				Owings Mills, Md.		DATE		SEP 24 1968 <u>Charles Judge</u>				

MEDICAL CERTIFICATION



12637

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
Eva		M.		Malloy	September 16, 1968		10:30 a.m.	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
female	Negro		April 30, 1900		68	4 16		
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.	U. S.				Baltimore		Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. Usual OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		SPRING GROVE STATE HOSP.		housewife				
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.		Harford		Havre DeGrace				213 North Stokes St.
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Hattie Chap		Galloway			Harriet		Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT				
		217-03-0978		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease								
4129 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
7221 Late, Latent syphilis								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that (X) (this hospital) attended the deceased from March 26, 19 65, to Sept. 16, 19 68, that (I) (we) last saw the deceased alive on Sept. 16, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Diomidis L. Pirovolidis				DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9-16-68
22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		Sept. 21, 1968		Washington Cemetery		Washington Harford Md		
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Dorothy E. Bullock				Harford State Md		SEP 19 1968		Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12638									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) ^{First} William ^{Middle} Francis ^{Last} Mannel						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month ^{Sept} 1 19 ⁶⁸ Year		2b HOUR 7:00 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 7-21-1895		6 AGE (in years last birthday) 73 YRS		7c DATE PRONOUNCED DEAD ^{Month} Sept. ^{Day} 1 19 ^{Year} 68	
7a BIRTHPLACE (State or foreign country) Balto., Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10 CITY OR TOWN OF DEATH Randallstown, Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Morgan Hill work Co.	
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE Md				13b COUNTY Balto.,		13c CITY OR TOWN Randallstown		13d INS DE CITY LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME ^{First} ? ^{Middle} ? ^{Last} Mannel				15 MOTHER'S MAIDEN NAME ^{First} Emilie ^{Middle} ? ^{Last} ?					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO. 215-03-1689		17. INFORMANT Mrs. Wm F. Mannel-9009 Mancellette Ave		ADDRESS Randallstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 412.7 Coronary Artery Disease. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COND.T ON GIVEN IN PART 1(a) 4201									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm street, factory office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE J. Nelson McKay M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Sept. 1, 1968	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town or county)					
23a BURIAL, CREMATION, REGIONAL (Specify)		23b DATE 9/4/68		23c NAME OF CEMETERY OR CREMATORY Mt. Olive		23d LOCATION (City or Town) (County) (State)		Randallstown, Md.	
24 FUNERAL DIRECTOR Xiong Byers 8728 Liberty Road Randallstown, Md 21133				25a REC'D BY REGISTRAR SEP 4 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12639

CERTIFICATE OF DEATH

12819

1 DECEASED NAME (Type or print) Florence M/ Mazer			2a DATE OF DEATH Month Sept. Day 9 Year 1968			2b HOUR 5P.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH August 12, 1890		6 AGE (in years or birthday) 78		IF UNDER 1 YEAR MONTHS YRS		
7a BIRTHPLACE (State or foreign country) Newport News Va.		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co.				
10. CITY OR TOWN OF DEATH Towson, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Balto. Co.		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7422 Monita Rd.		
14. FATHER'S NAME First Kabe Middle Millman Last Rachael			15 MOTHER'S MAIDEN NAME First Rachael Middle Millman Last Rachael							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address Mr. Norman S. Mazer 7422 Monita, Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 334X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) General & cerebral arteriosclerosis with aneurysm of basilar artery & arteriovenous aneurysm										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May, 1966 , to Sept 9, 1968 , that (I) (we) lost saw the deceased alive on Sept 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jonas Cohen M.D.				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Sept. 10th. 1968		
22d. PHYSICIAN'S NAME (Type) Dr. Jonas Cohen				22e. ADDRESS 6702 Park Hts. Ave.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 10th. 1968		23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh		23d. LOCATION (City or Town) (County) (State) Woodlawn Baltimore Md.				
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son P.O. Box 65 Garrison, Md.				25a. REC'D BY REGISTRAR DATE SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12640

CERTIFICATE OF DEATH

12650

1. DECEASED NAME (Type or print) VERNON J. MC CALL			2a. DATE OF DEATH Month 9 Day 12 Year 68 2b. HOUR 9:20A		
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 4/6/20		6. AGE (In years last birthday) 48 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE COUNTY,		Md.			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) JANITOR	
12b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1939 W. LAFAYETTE AVENUE
14. FATHER'S NAME First BENJAMIN Middle MC CALL Last OLIVER		15. MOTHER'S MAIDEN NAME First BERTHA Middle OLIVER Last OLIVER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO 220 09 60 12		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG WITH WIDESPREAD METASTASES 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1621 X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/10/68 , 19____, to 9/12/68 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/12/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Peter V. Juvan</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/12/68	
22d. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/16/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR <i>Marshall P. Hayes</i>		ADDRESS HAYES FUNERAL HOME		25a. RECD BY REGISTRAR SEP 13 1968	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS 638 N. Gilmore St. Baltimore, Md.			



FOR STATE HEALTH DEPT.

12641 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12651

1. DECEASED NAME (Type or Print) <i>Agnes M. McCarty</i>			2a. DATE KNOWN OF DEATH: <input checked="" type="checkbox"/> Month <i>September</i> Day <i>30</i> Year <i>1968</i>			2b. HOUR <i>M</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Jan. 21, 1883</i>	6. AGE (in years and birthday) <i>85 YRS</i>	7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8. IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>September</i> Day <i>30</i> Year <i>1968</i>		2d. HOUR <i>M</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>USA</i>		8. MARR ED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore,</i>		
10. CITY OR TOWN OF DEATH <i>Lutherville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Stella Maris Hospice</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RES DENCE (Where deceased lived, if institution Res dence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <i>4817 Arabia Avenue</i>								
14. FATHER'S NAME First <i>Ephriam</i> Middle <i>Eckenrode</i> Last <i>Elizabeth C. Elder</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>C.</i> Last <i>Elder</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>217-46-0843</i>		17. INFORMANT <i>Mr. John V. McCarty, 3040 Woodring Ave</i>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bladder Infection + Torn Urethra</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fracture Pelvis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Weeks</i> <i>27 Days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <i>Sept 3, 1968</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fell in own Bedroom</i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>3:30 AM Sept 3, 1968</i>			21b. TIME OF INJURY Month, Day Year <i>3:30 AM Sept 3, 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell in own Bedroom</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <i>Nursing Home</i>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Nursing Home</i>			21f. LOCATION Street or R.F.D. No <i>Pot Spring Rd - Lutherville - Baltimore</i>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>			EXAMINER'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>			22b. DATE SIGNED <i>10/2/68</i>		
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <i>Burial</i>			23b. DATE <i>10/3/68.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>					25a. REC'D BY REG STRAR DATE <i>OCT 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

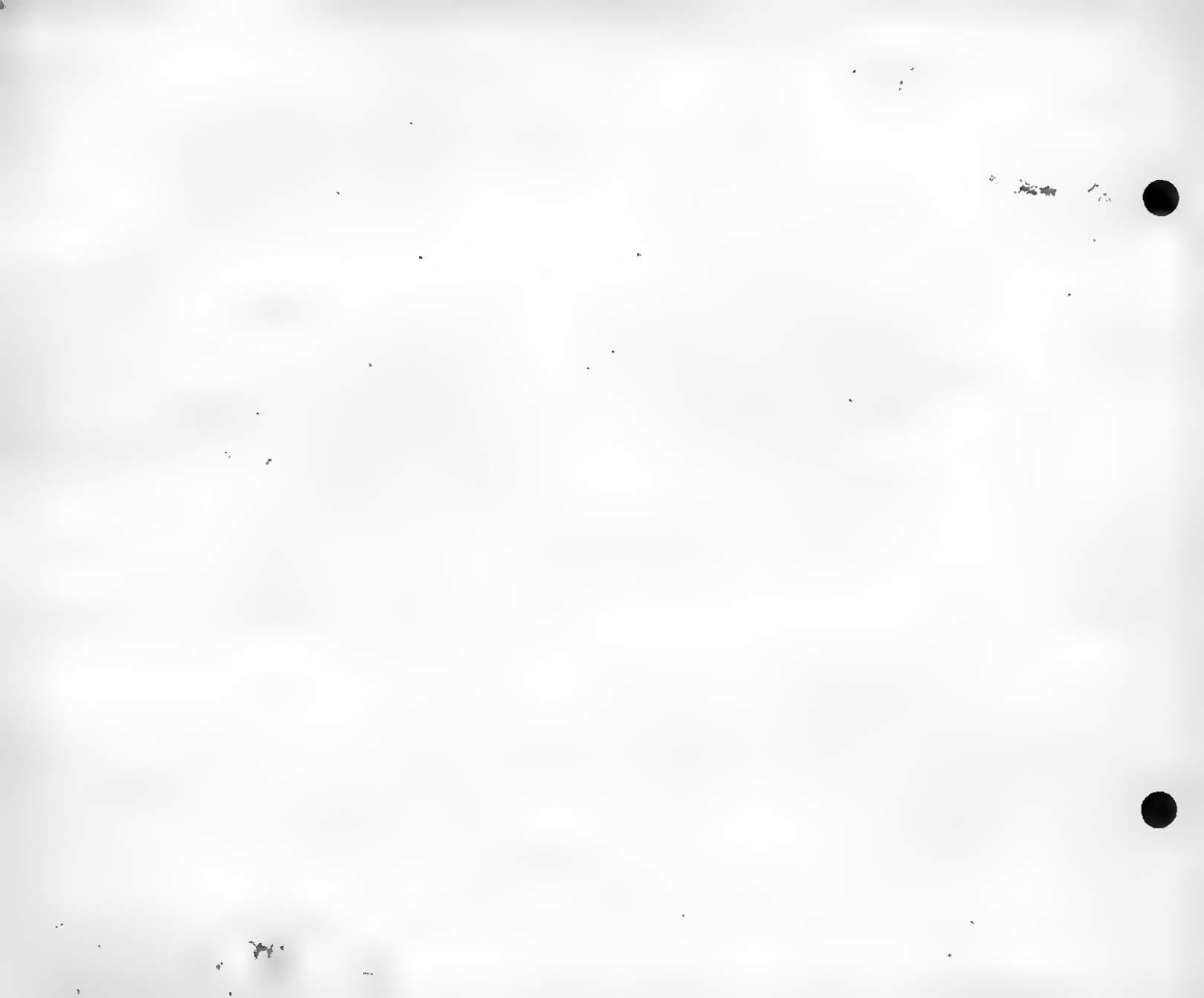
12652

12642

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalls Town</u>		c. LENGTH OF STAY IN 1b) <u>dead on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Balto. County General Hospital</u>				d. STREET ADDRESS <u>10 Old Court Rd.</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Cecilia</u> Last <u>McCoy</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1968</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1890</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Eusandia Morgan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mr. Carter McCay, 110 McHenry Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4107 DUE TO <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Sept. 1968</u> ; that (I) (we) last saw the deceased alive and about <u>3 weeks prior</u> and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Gerald Maggill</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/22/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gerald Maggill M.D.</u>				22d. ADDRESS <u>Pikesville Medical Center, Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 26, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

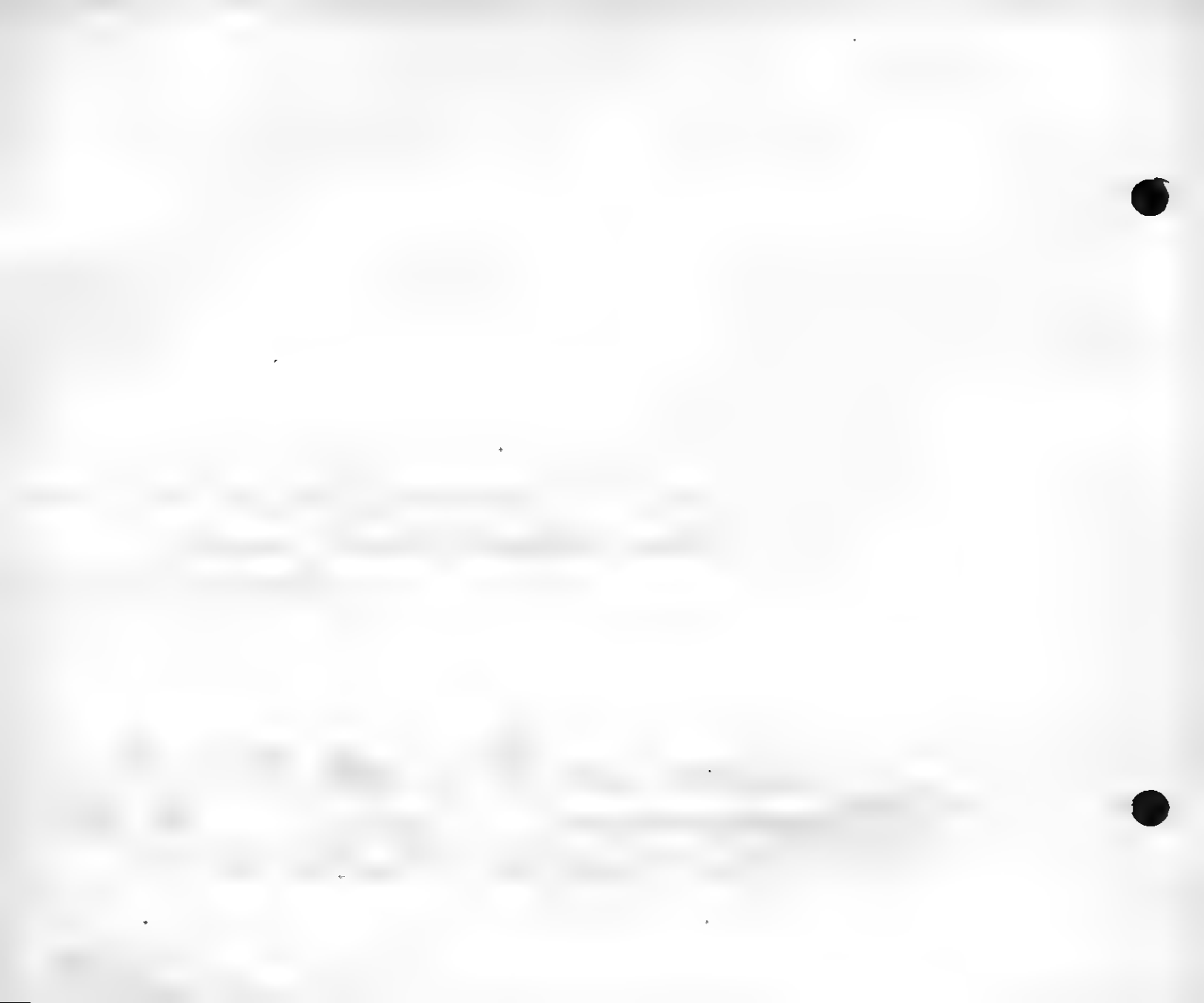


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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12643 CERTIFICATE OF DEATH 12553									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural BALTIMORE c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6302 Golden Ring Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural BALTIMORE d. STREET ADDRESS 6302 Golden Ring Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JULIA K. McCUBBIN					4. DATE OF DEATH Sept. 13, 1968				
5. SEX female		6. COLOR OR RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1887		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Kirby					14. MOTHER'S MAIDEN NAME Sarah Foote				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 218-14-0854		17. INFORMANT'S NAME Mrs. Charles Trueman Address (Same)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Infarction 4109 DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 10 yrs								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968 to Sept 13, 1968 , that (I) (we) last saw the deceased alive on Sept 12, 1968 , and that death occurred at 5A M, from the causes and on the date stated above.									
22a. SIGNATURE M. Baumgardner					22b. DATE SIGNED 9/13/68		22c. PHYSICIAN'S NAME (Type) M. BAUMGARDNER		
22d. ADDRESS Balto-21237					22e. M.O. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/16/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.-14					25a. REC'D BY REGISTRAR SEP 13 1968 25b. REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tab papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or interment, within 72 hours after death.

VR A15
304 REV

12644

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12654
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Elizabeth Cicilla McDonnell			2a DATE OF DEATH Month 9 Day 21 Year 68			2b HOUR 10:40 MIN M					
3 SEX Female		4 RACE White		5 DATE OF BIRTH 10-19-1901		6 AGE (In years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Spring Grove State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY None			
13a U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2930 Riggs Ave.			
14 FATHER'S NAME First Michael Middle McGillen Last McGillen			15 MOTHER'S MAIDEN NAME First Roseann Middle Troy Last Troy								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>			16b SOCIAL SECURITY NO -			17 INFORMANT Spring Grove State Hosp. Catonsville, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 4357 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) + APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-1-68											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 11-6-1953 to 9-21-1968 , that (I) (we) last saw the deceased alive on 9-21-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Juan Gan M.D.				DEGREE MD				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 9/21/68	
22d. PHYSICIAN'S NAME (Type) Juan Gan M.D.				22e ADDRESS Spring Grove State Hosp							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 9/24/68		23c NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				23d LOCATION (City or Town) 4300 4th St. Baltimore, Md. (County) (State)			
24 FUNERAL DIRECTOR John J. Cowan				ADDRESS 1201 N. Hollister St.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
DATE SEP 24 1968											



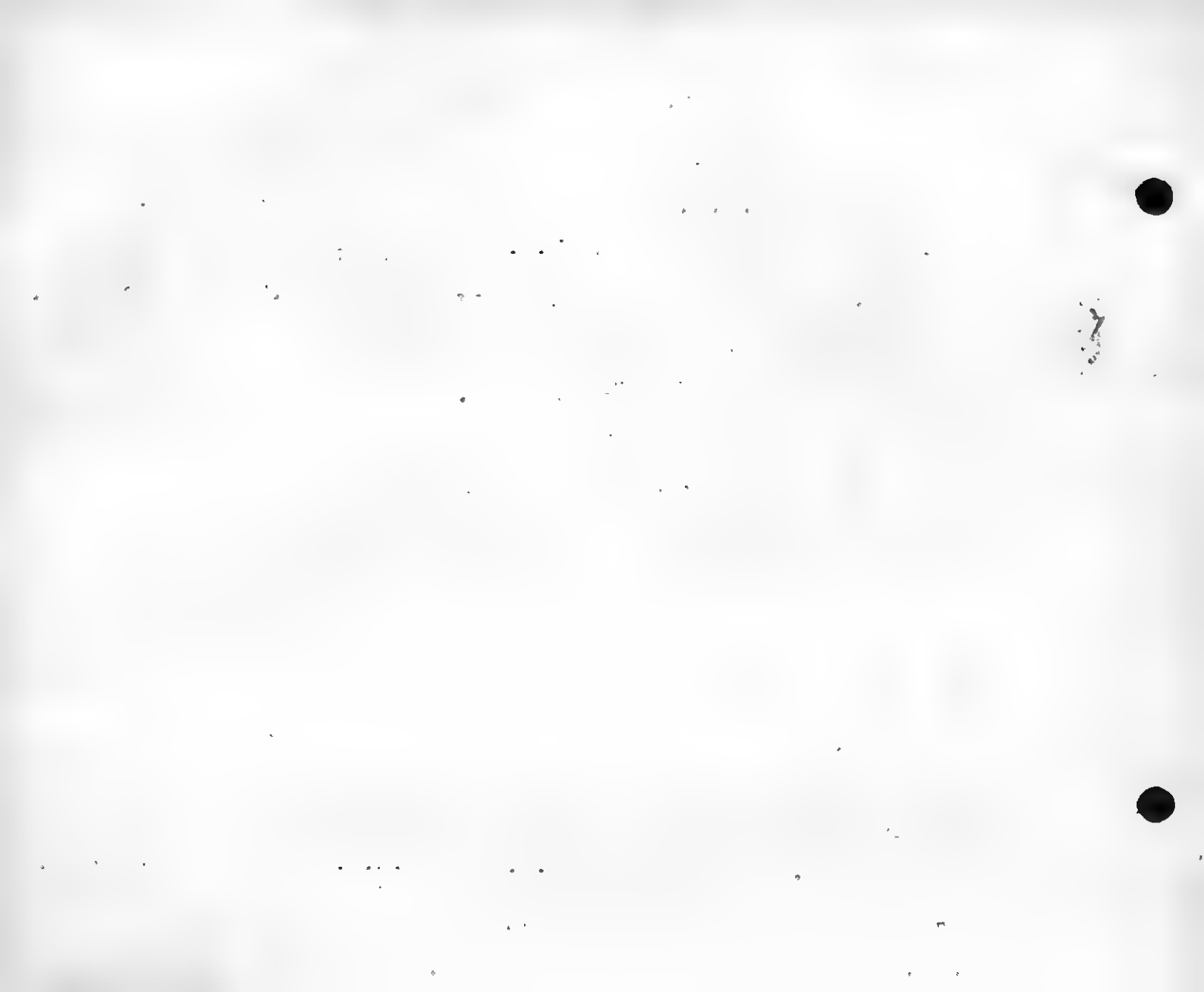
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12655

1 DECEASED-NAME (Type or print) Owen			First C. Middle McFadden Last			2a. DATE OF DEATH 9 Month 22 Day 68 Year			2b. HOUR 6 MIN P		
3. SEX Male			4 RACE WHITE			5. DATE OF BIRTH 1/20/02			6. AGE (In years last birthday) 66 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. C.T. ZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Co.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) REAL ESTATE			12b. KIND OF BUSINESS OR INDUSTRY BROKER		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 6012 HUNT RIDGE RD.			14. FATHER'S NAME First FRANCIS Middle P. Last McFADDEN			15. MOTHER'S M.A.DEN NAME First HELEN Middle CHESTER Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 215-12-0981			17. INFORMANT MRS. OWEN C. McFADDEN			Address 6012 HUNT RIDGE RD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4369 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes 22 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 9/1 , 19 68 , to 9/22 , 19 68 , that he (we) last saw the deceased alive on September 22 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (we) did (did not) view the body after death.											
22b. SIGNATURE B. R. Friedlander MD						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/22/68 21204		
22d. PHYSICIAN'S NAME (Type) Dr. B.R. Friedlander M.D.			22e. ADDRESS G.B.M.C. 6701 N. Charles St.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9/25/68			23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.		
24. FUNERAL DIRECTOR H. W. MEARS & SON			ADDRESS 805 N. CALVERT ST.			25a. REC'D BY REGISTRAR SEP 26 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Part 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 15156 (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12656	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
JOSEPH			A.		MCKUSKY				Month Day Year		UNK M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
male	white	Jan. 20, 1916		52 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		6:30 p.m.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH				
Pennsylvania			U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Arbutus			4854 Carmella Drive					Mechanic		D C of A.	
13a USUAL RESIDENCE (Where deceased last admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY (UM 157)		13e STREET AND NUMBER		
Maryland			Baltimore		Arbutus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4854 Carmella Drive		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S M.A.DEN NAME		
Joseph McKusky									Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
NO			165-18-3850		Anne Abramowicz, 10 Smiffen St. Norwalk Conn						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			9/27/68		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Oct. 3, 1968		Loudon Park Cemetery			Baltimore City, Maryland			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard, 4107 Wilkens Ave. Baltimore			21229			DA OCT 4 1968			J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12647

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12657

1 DECEASED-NAME (Type or print) <u>WILLIAM J McLaughlin</u>			2a. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1968</u>			2b. HOUR <u>4:00</u> AM	
3 SEX <u>M</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Nov. 20 1894</u>		6 AGE (In years last birthday) <u>73</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Ireland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Baltimore</u> Md.	
10. CITY OR TOWN OF DEATH <u>Parkville</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>8607 Wendal Ave</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Engineer Agn</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Dus Co.</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MD</u>		13b. COUNTY <u>DALTON</u>		13c. CITY OR TOWN <u>Parkville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>8607 Wendal Ave</u>		14. FATHER'S NAME First Middle Last <u>William McLaughlin</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Elizabeth Doherty</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <u>202-22-3285</u>		17 INFORMANT Address <u>Lucille McLaughlin Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Corn Pulmonale</u> (b) <u>Emphysema & Fibrotic lungdis</u> DUE TO OR AS A CONSEQUENCE OF (c) <u></u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5071</u> <u>NO</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-3.5 yrs</u>
19a. DATE OF OPERATION <u>5/27/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>19</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u></u>			
21d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u></u>		21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1968</u> , to <u>Sept 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 18 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. F. T. Kasik Jr.</u>		DEGREE <u>F.T. KASIK JR.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9/27/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>F.T. KASIK JR.</u>		22e. ADDRESS <u>7005 HARTFORD RD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9/30/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith</u>		23d. LOCATION (City or Town) (County) (State) <u>DALTON MD</u>	
24. FUNERAL DIRECTOR <u>C. F. EVANS JR.</u>		ADDRESS <u>8802 Hartford Rd</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>12648</div> <div>CERTIFICATE OF DEATH</div>											
1 DECEASED-NAME (Type or print) James Roderick Mecredy						2a. DATE OF DEATH 9 Month 22 Day 68 Year			2b. HOUR 10 a^m		
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Sept. 3, 1888		6 AGE (In years lost birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Roanoke, Va.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Co.			Md.		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. Cen.		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Retired-Engineer		12b KIND OF BUSINESS OR INDUSTRY Chemical					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Baltimore Towson		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 204 E. Joppa Road			
14. FATHER'S NAME First Middle Last James Mecredy				15 MOTHER'S MAIDEN NAME First Middle Last Charlotte Edwards							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 215-10-5750A		17 INFORMANT Address Mrs. Catherine M. Mecredy (Same)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery thrombosis											
4129 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardio vascular Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that Dr. Charles C. Brown (this hospital) attended the deceased from 9/21 , 1968, to 9/22 , 1968, that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 22 , 1968, and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D.				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 9/22/68			
22d. PHYSICIAN'S NAME (Type) Dr. Charles C. Brown M.D.				22e. ADDRESS G.B.M.C. 6701 N. Charles St. 21204							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/25/68		23c NAME OF CEMETERY OR CREMATORY Evergreen		23d LOCATION (City or Town) Roanoke		(County) Va.		(State)	
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a REC'D BY REG. STR. SEP 24 1968		25b REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 11-78

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12649 CERTIFICATE OF DEATH 12659											
1. DECEASED-NAME (Type or print) First Middle Last MARY ANN MERRYMAN						2a. DATE OF DEATH 9 Month 15 Day 68 Year		2b. HOUR 9:55 A.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH 8/30/1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.					
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE-IN-THE-PINES			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 15 ST. TIMOTHY LA.			
14. FATHER'S NAME First Middle Last HENRY ELLSWORTH BLOOM				15. MOTHER'S M.A.DEN NAME First Middle Last BARBARA ANN DWERLING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service) —		16b. SOCIAL SECURITY NO. None		17. INFORMANT Helen M. Lacey		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-Vasc. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 103 min.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42 x 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9-8-1968 to 9-13-1968, that (I) (we) last saw the deceased alive on 9-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE Wilmer K. Gallager, M.D.						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-16-68	
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallager, M.D.						22e. ADDRESS 6209 Frederick Ave., Baltimore, Md. 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/17/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) BALTIMORE Md					
24. FUNERAL DIRECTOR E.S. Mac Nabb						ADDRESS 301 Frederick Rd. Baltimore 28 Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

12650

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12660

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) Edna V. Metcalf			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 9-26 1968 1A M			2b. HOUR			
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 27, 1912	6. AGE (In years last birthday) 56 YRS	7. UNDER 1 YEAR MONTHS 0 DAYS 0	8. UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month Sept. Day 26 Year 1968 2d. HOUR 12 PM			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7839 St. Fabian Lane			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Grants Dept. Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7839 St. Fabian Lane	
14. FATHER'S NAME First Ollie Middle Harlow Last Harlow			15. MOTHER'S MAIDEN NAME First Noah Middle Roadcap Last Roadcap			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO 227-28-9836			17. INFORMANT (Husband) Mr. Melvin Metcalf, 7839 St. Fabian Lane			18. ADDRESS Dundalk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension C-V-Disease 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
22. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 6800 Morningside Rd. ACTUAL SIGNATURE Melvin B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Melvin B. Davis M.D. Charles Judge 22b. DATE SIGNED 9/27/68 Dundalk, Md. 21222									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Mem. Park		23d. LOCATION (City or Town) (County) (State) Keyser, Mineral Co. W.Va.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

2021



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

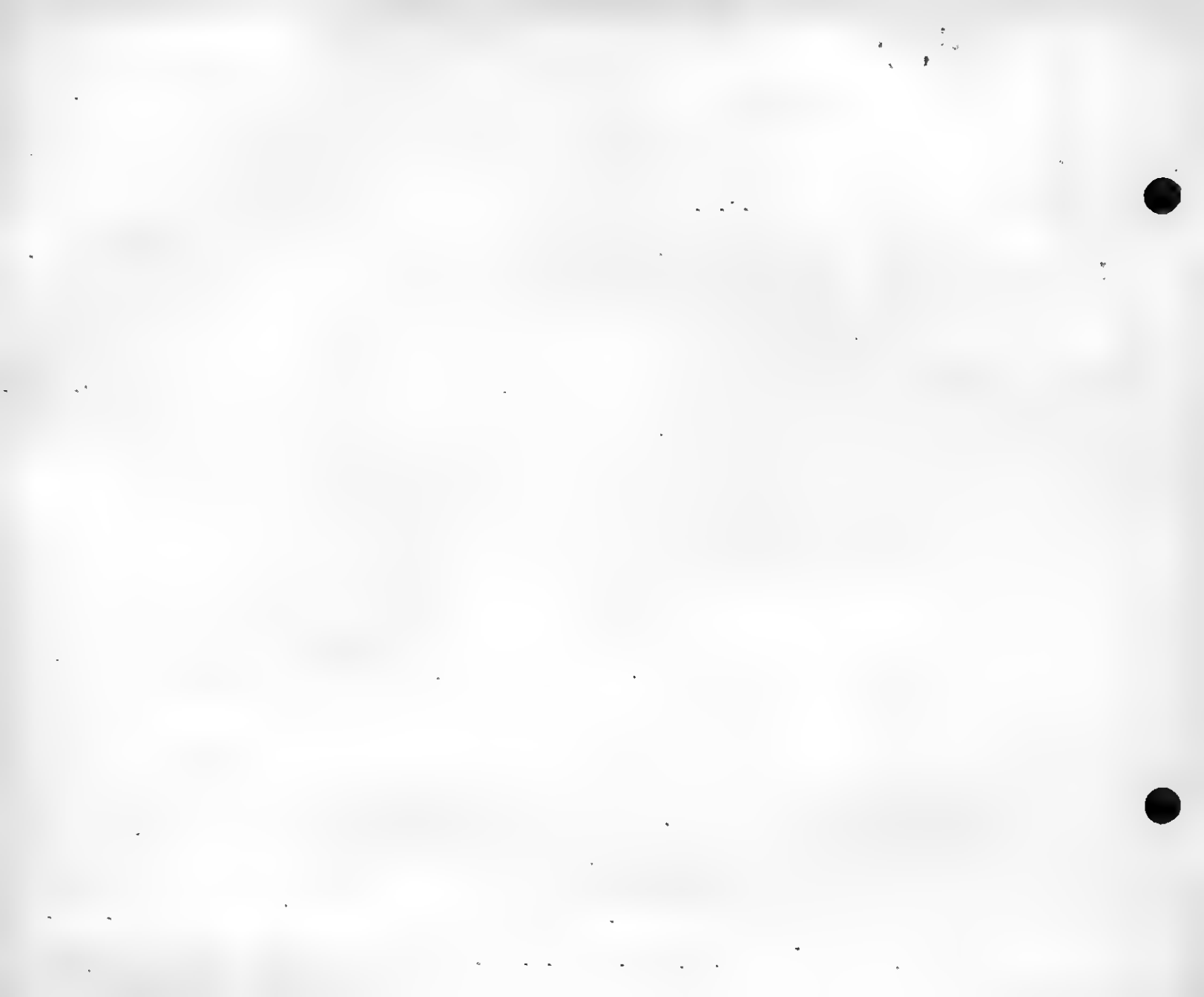
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12651

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12661

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR	
Walter ERNEST MEYER						9/10/68					1968	8:05 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS.		2c DATE PRONOUNCED DEAD			2d HOUR		
male	white	1-13-1909	59 YRS	MONTHS	DAYS	HOURS	MIN.	September 10, 1968			8:05 A.M.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH							
Germany		U.S.A.		W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore Md							
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR IND. STRY.				
Towson			St. Joseph's			Executive			Bendix Corp.				
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER				
Maryland			Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		204 E. Joppa Road				
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Norman					Mayer	Martha					Staroffeld		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			YES			Mrs. Lillian Meyer			3418 Glen Eagles Dr. S.S., Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
6164													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			7:30 AM 9/10 1968			Operator of auto - was struck head-on by another car							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town		County State		
			street						Baltimore, Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Werner U. Spitz			Werner U. Spitz, M.D.									22b DATE SIGNED	
												9/10/68	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)		
Burial			9-16-1968		St. Lincoln Crematory			Bladesboro N.C.			Md.		
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
Charles E. Jones						SEP 16 1968			f Charles Jones				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

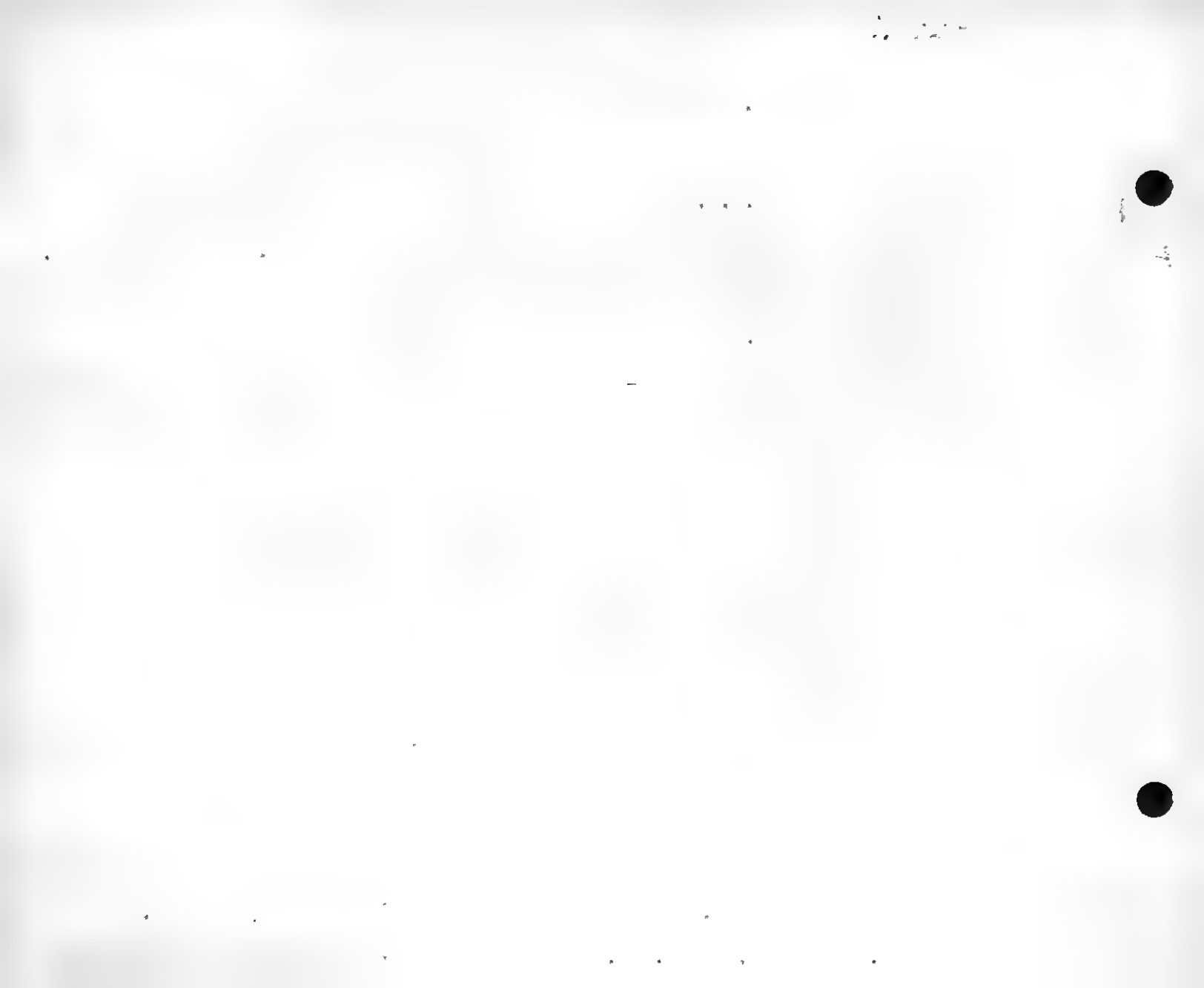
12652

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12662

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Albert F. Miller			2a DATE OF DEATH Month SEP Day 15 Year 1968			2b HOUR 9:40 AM					
3. SEX Male		4. RACE white		5. DATE OF BIRTH March 10, 1882		6. AGE (In years last birthday) 86 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.					
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Capt. Balto.			12b. KIND OF BUSINESS OR INDUSTRY Fire Dept.		
13a U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland			13b COUNTY Baltimore City			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 1922 Swansea Road		
14 FATHER'S NAME First Middle Last (deceased) Albert F. Miller			15 MOTHER'S MAIDEN NAME First Middle Last (deceased) ? ?								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO 217-26-0791			17 INFORMANT Address Records: Spring Grove State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 177X (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCVD											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I (this hospital) attended the deceased from November 3, 1967 , to 15 Sept, 1968 , that (I) (we) last saw the deceased alive on 15 Sept 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.A. DEAR JR MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>									22c DATE SIGNED 15 Sept 68		
22d. PHYSICIAN'S NAME (Type) W.A. DEAR JR MD									22e ADDRESS Spring Grove State Hospital		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 9/18/68.			23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d LOCATION (City or Town) (County) (State) Baltimore, Md.		
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a REC'D BY REGISTRAR SEP 16 1968			25b REGISTRAR'S SIGNATURE Charles Judge		



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 405 MARYLAND STATE DEPARTMENT OF HEALTH
9-30-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12663

12653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) ETHEL E. MILLS			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9-15 1968			2b HOUR M		
3 SEX Female	4 RACE White	5. DATE OF BIRTH Nov. 3, 1925	6. AGE (In years last birthday) 42 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month September Day 15 Year 1968		
7a BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6660 Lock Hill Road
14 FATHER'S NAME First Middle Last Wm. E. Fetherolf			15 MOTHER'S MAIDEN NAME First Middle Last Ethel M.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-26-7747		17. INFORMANT Mr. Durward A. Mills			ADDRESS 6660 Lock Hill Rd-12	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose of barbiturate DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 770-								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 9-15 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took overdose				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No 6660 Lock Hill Rd.		City or Town Towson		County Baltimore
						State Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED September 16, 1968		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 9/19/68		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.		23d. LOCATION (City or Town) Baltimore		(County) (State)
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home Inc.				ADDRESS 6500 York Road 21212		25a. REC'D BY REGISTRAR DATE SEP 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

100-10000

100-10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12654
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE 21219 MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7340 WALDMAN AVE				d. STREET ADDRESS 7340 Waldman Ave.			
3. NAME OF DECEASED (Type or print) VERNON LEE MOORE				4. DATE OF DEATH Month SEPT. Day 27 Year 1968			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 16, 1912	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TANDEM OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE CO. MD	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME LEE MOORE		14. MOTHER'S MAIDEN NAME ELLA ZEIGEL HEAVER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. 213-09-0043		17. INFORMANT S. Josephine Moore - as in #1		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia Conditions, if any, which gave rise to immediate cause (b) Glio blastoma (c) 1124 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1131		INTERVAL BETWEEN ONSET AND DEATH 7 days on April 26, 1968	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 26, 1968 to Sept 27, 1968 that (I) (we) last saw the deceased alive on Sept 27, 1968 , and that death occurred 7:20 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Louis N. Tollin		22b. DATE SIGNED Sept 27, 1968		22c. PHYSICIAN'S NAME (Type) LOUIS N. TOLLIN		22d. ADDRESS 6908 N. Pt. Rd. Balt Md 21219	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR OCT 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1905

1905

1905

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. (File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

12665

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12665

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
WILLIE JAMES MOORE						Month Day Year			7:38 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	Negro	June 16, 1908	60 YRS.	MONTHS	DAYS	HOURS	MIN	September 8,			7:38 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Towson		USA				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph's Hosp.									
13a. USUAL RESIDENCE (Where deceased lived 1 year or more before death)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		651 Cheraton Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Charles Moore			Maxie Hill								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						General Moore			651 Cheraton Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
443x											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			9/10/68		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Towson		Sept 13/68		Mt Calvary Cem.		A. A. County		Md			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Milton E. Elickson						SEP 13 1968		Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12656

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12666

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9 25 1968			2b. HOUR 12 am		
JAMES			B.			MOWBRAY					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	Nov 9 1914	53 38					Sept. 25 19 68			12a m
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md		
Massachusetts		U. S. A.				Balto.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk			Y.M.C.A.			Pipefitter			Gen'l Dynamic		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			14. CITY OR TOWN			13c. STREET AND NUMBER		
Mass.						Holbrook			YES <input type="checkbox"/> NO <input type="checkbox"/> 37 Holiday Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
James H. Mobray			Euphemia Smart								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			024-03-4874			Mary J. Mowbray			37 Holiday Rd. Holbrook Mass.		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>4021</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 9/25/68		
Edward F. Wilson, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			9-28-68			Mt. Wollaston Cemetery			Holbrook, Massachusetts		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Howard H. Hubbard 4107 Wilkens Avenue 21229						DATE SEP 27 1968			J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12657

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12667

1. DECEASED NAME (Type or print) EMMA MARGARET MURPHY			2a. DATE OF DEATH Month 9 Day 23 Year 68		2b. HOUR 5:30AM
3 SEX FEMALE	4 RACE CAUC.	5 DATE OF BIRTH 12-26-07		6 AGE (In years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE COUNTY Md		
10. CITY OR TOWN OF DEATH TOWSON, MARYLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3210 Lawnview Avenue
14. FATHER'S NAME First Ludwig Middle Gruber Last Gruber		15. MOTHER'S MAIDEN NAME First Katherine Middle Stadler Last Stadler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Mr. John B. Murphy Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 174X DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF BREAST DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-29 , 19 68 , to 9-23 , 19 68 , that (I) (we) last saw the deceased alive on 9-23-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Meshkinpour				22c. DATE SIGNED 9/23/68	
22d. PHYSICIAN'S NAME (Type) DR. H. MESHKINPOUR				22e. ADDRESS GBMC	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/27/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23e. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland				25a. REC'D BY REGISTRAR DATE SEP 24 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

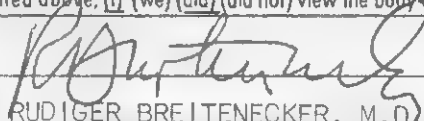

VR 1-1-68
30M REV 1-68

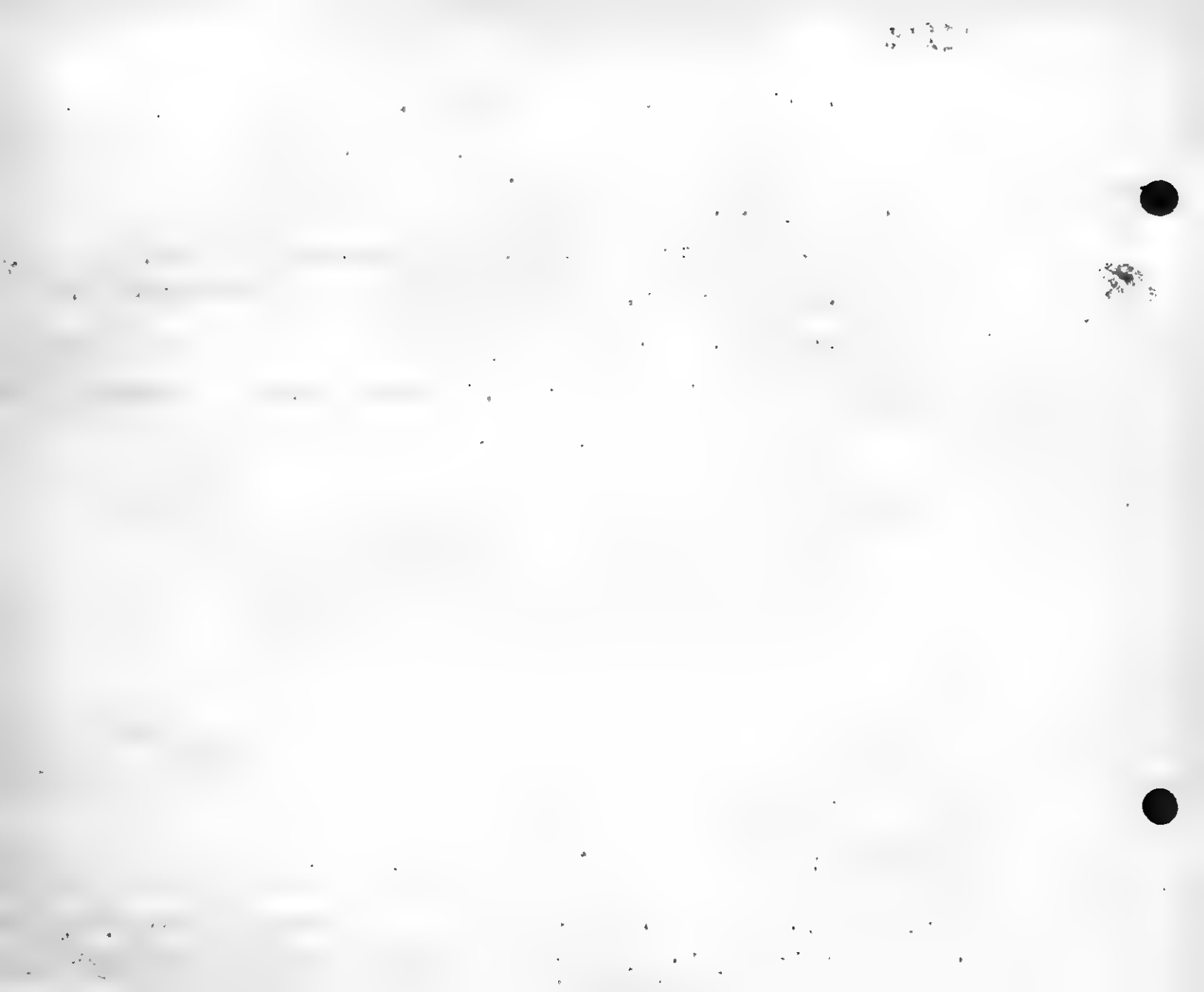
12652

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12668

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) FRANCIS			First P.			Middle MURRAY, Jr.			Last			2a. DATE OF DEATH 9 Month 10 Day 68 Year			2b. HOUR 1:20P M		
3 SEX Male			4 RACE Cau.			5. DATE OF BIRTH Jan. 18, 1919			6. AGE (In years last birthday) 49 YRS			7. UNDER 1 YEAR MONTHS DAYS HOURS M.N.			IF UNDER 24 HRS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.								
10. CITY OR TOWN OF DEATH Baltimore, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cen.			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Md. Glass Co.								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 7102 Sheffield Rd.					
14. FATHER'S NAME Francis P. Murray			First Middle Last			15. MOTHER'S MAIDEN NAME Harriet Doolittle			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes			(If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO 199-09-0053			17. INFORMANT Mrs. Elizabeth Murray			Address (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral edema and metastases</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of right lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>68</u> , to <u>9/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/10/68											
22d. PHYSICIAN'S NAME (Type) RUDIGER BREITENECKER, M.D.			22e. ADDRESS Greater Baltimore Medical Center														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/13/68			23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md.								
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			4905 York Rd. Balto., Md.			25a. REC'D BY REGISTRAR SEP 13 1968			25b. REGISTRAR'S SIGNATURE 								



12659

CERTIFICATE OF DEATH

12669

1 PLACE OF DEATH a COUNTY <u>Balto. Co.</u> <u>3803 OAK AVE.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>21 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3803 Oak Ave.</u>		d. STREET ADDRESS <u>3803 Oak Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ada.</u> Middle <u>May</u> Last <u>Myers</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/17/77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>seamstress</u>	9 AGE (In years last birthday) yrs. <u>91</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>Alfred Baker Myers</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Clementine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-4044</u>	
17. INFORMANT <u>Lillian Burkhardt</u>		Address <u>3803 Oak Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>+ a74</u> DUE TO <u>atrial fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1960</u> , to <u>9/22, 1968</u> , that (I) (we) last saw the deceased alive on <u>9/24, 1968</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Gerald N. Maggidi</u>		22b. DATE SIGNED <u>9/22/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gerald N. Maggidi</u>		22d. ADDRESS <u>Pikesville Medical Center Pikesville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-25-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE Cemetery - Balto Md -</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto Md -</u>
24 FUNERAL DIRECTOR <u>ELLSWORTH ARMACOST - 4600 Liberty Heights.</u>		25a. RECD BY REGISTRAR <u>SEP 24 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Richard J. Young</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12660

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12660

1. DECEASED-NAME (Type or print) First Middle Last Elizabeth H. Neilson			2a. DATE OF DEATH Month Day Year Sept 4 1968		2b. HOUR 6:30 P.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH 5-8-89		6 AGE in years (last birthday) 79 YRS	7 FINDER 1 YEAR MONTHS DAYS HOURS M N
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Baltimore County		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary-	
13a U.S.A. RESIDENCE (Where deceased lived if not in U.S.A. residence before admission) STATE Maryland		13b COUNTY Baltimore	13c CITY OR TOWN Randallstown	13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Milton Houck		15. MOTHER'S MAIDEN NAME First Middle Last Agnes Amos			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16b SOCIAL SECURITY NO —		17 INFORMANT Address FRANK FURST HOUCK - 2601 LARCHMONT DR	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>471X</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ASCD, old myocardial infarction, Cerebro-vascular insufficiency</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 22</u> , 19 <u>68</u> , to <u>Sept 4</u> , 19 <u>68</u> , that (I) (we) <u>D</u> saw the deceased alive on <u>Sept 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>D</u> (did not) view the body after death.					
22b SIGNATURE <u>Gregorio Mayfor</u>		22c. DATE SIGNED <u>Sept 4, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>Gregorio Mayfor</u>	
22e ADDRESS <u>Ellsworth Armacost - 4600 Liberty Heights</u>		22f DEGREE DEGREE		22g MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-6-68</u>		23c. NAME OF CEMETERY OR CREMATOR <u>White Plains</u>	
23d. LOCATION (City or Town) <u>White Plains, N.Y.</u>		23e. REC'D BY REGISTRAR <u>SEP 6 1968</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH 12661 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last J. Brooks Nichols Jr.			2a. DATE KNOWN OF ESTI- DEATH MATED September 16 1968 7A M			2b. HOUR		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 5 3 1909	6 AGE (in years last birthday) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year September 16 1968 7A M		2d. HOUR
7a. BIRTHPLACE (State or foreign country) N.Y. N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 121 Marburth Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Div. Director		12b. KIND OF BUSINESS OR INDUSTRY Appeal
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last J. Brooks Nichols			15. MOTHER'S MAIDEN NAME First Middle Last Rosa Dunlap			16. SOCIAL SECURITY NO 528 07 4647		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			17. INFORMANT ADDRESS Grace Ashton Nichols 121 Marburth Av					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bullet Wound of Rt Temple DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State		
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 9/16/68		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Spec. by) Cremation			23b. DATE 9/16/1968			23c. NAME OF CEMETERY OR CREMATORY Greenmount		
23d. LOCATION (City or Town) Baltimore			23e. COUNTY Md.			23f. STATE		
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home			ADDRESS 6500 York Rd.			25a. REC'D BY REGISTRAR DATE SEP 18 1968		
25b. REGISTRAR'S SIGNATURE Charles Judge								

7

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

126572

1. DECEASED NAME (Type or print)		First	Middle	Last	SR.	2a. DATE OF DEATH		2b. HOUR	
JOSEPH C.				NOHE		Month	Day	Year	11:30 A.M.
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
MALE	White		4-14-1890		78 YRS		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Chesapeake Manor Nursing Home				Ship Sealer-Chesapeake ShipCo			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Balto.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Congress Hotel	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Charles Nohe			Walburga Kellner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			216-09-1667		4026 Lyndale Ave. Joseph C. Nohe, Jr. son,		21213		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Aspiration Pneumonia								hours	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Acute Gastroenteritis								2 days	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Arteriosclerotic Cerebrovascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (the hospital) attended the deceased from 19 to 9-13, 1968, that (I) (we) saw the deceased alive on 9-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
L. Kemper Owens M.D.		9/13/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Dr. L. Kemper Owens		6 E. Read St. Baltimore, Md. 21229							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		9/17/68		Holy Redeemer Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.		3331 Brehms Lane		DATE SEP 17 1968		J. Charles Judge			

2000



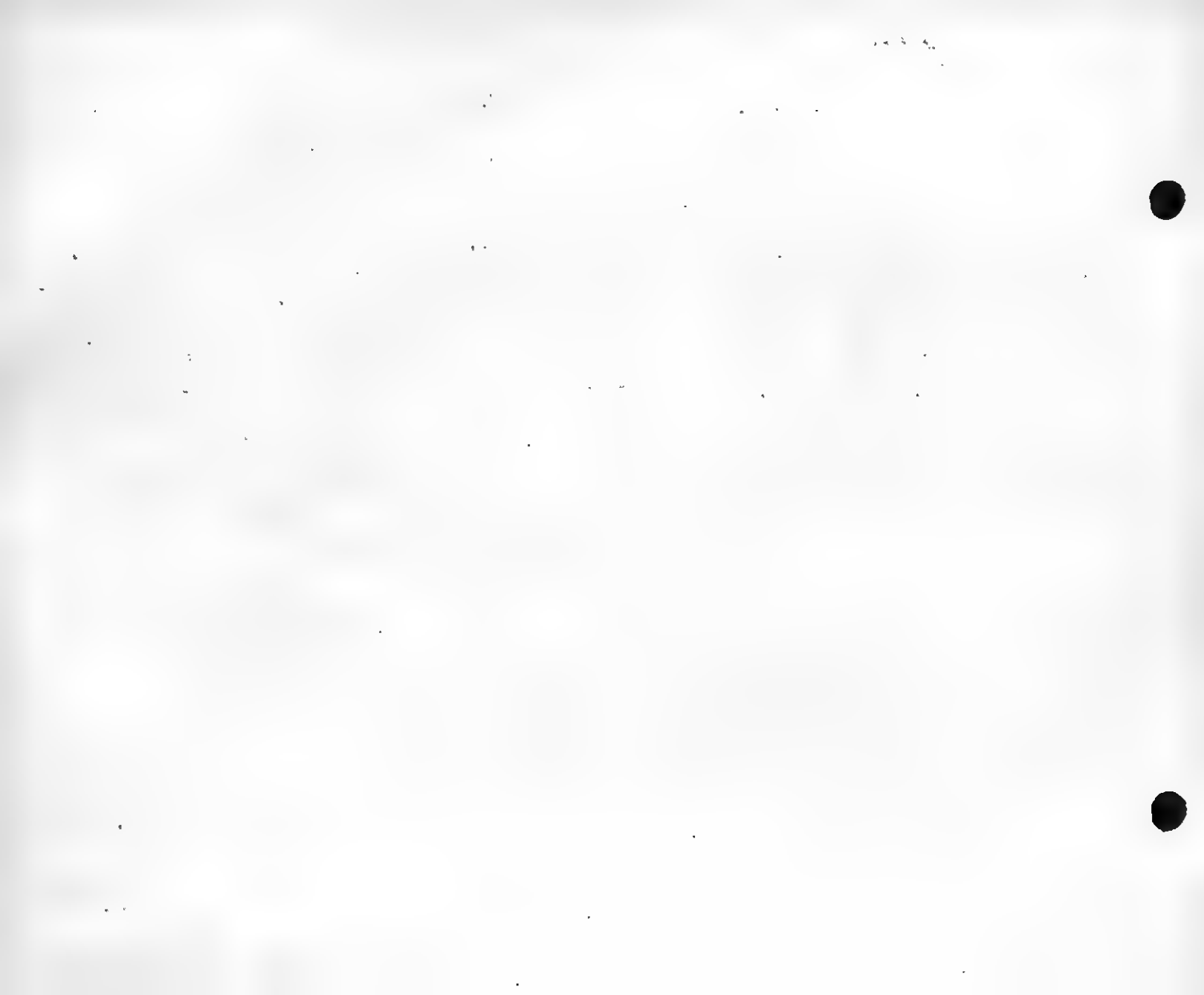
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12663		12663							
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH	Month	Day	Year	2b HOUR
WALBURG T. NOLAN					SEPT. 20 1968				M
3 SEX	F	4 RACE	W	5 DATE OF BIRTH	NOV. 25, 1880	6 AGE (in years last birthday)	87 YRS.	7 UNDER 1 YEAR	if UNDER 24 HRS.
7b. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Md.			
MD		U.S.A.	BALTIMORE						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working years)		12b KIND OF BUSINESS OR INDUSTRY			
CATONSVILLE		HODDS NURSING HOME		NURSE		HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER				
MD			BALTIMORE		706 MOUNTING PLACE				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
JOSEPH				MARG	MATHILDA HINKLEMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No				William B. Nolan-1727 Longford Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis</u>									
CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last.									
4129									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Several days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4221									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>9/19/68</u> to <u>9/20/68</u> , that (I) (we) lost saw the deceased alive on <u>9/19/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22d. PHYSICIAN NAME (Type)					
<u>W. B. Nolan</u>		<u>9/20/68</u>		BALTIMORE 28, MARYLAND					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		9-23-68		Cathedral Am.		Baltimore		Md.	
24 FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE			
<u>Farley Cronan</u>		DATE		SEP 24 1968		<u>Charles Judge</u>			



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12664

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12671

1 DECEASED-NAME (Type or print) <i>Mary Catherine C. Felt</i>			2a. DATE OF DEATH <i>9/18/68</i>			2b. HOUR <i>2:20 P.M.</i>			
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>3/2/1873</i>		6 AGE (In years last birthday) <i>95</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10 CITY OR TOWN OF DEATH <i>ROCKDALE</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8224 Liberty Rd.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWORK</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>ROCKDALE</i>		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>3625 FLORIDA RD</i>	
14 FATHER'S NAME First Middle Last <i>Bissett</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Singler</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b SOCIAL SECURITY NO <i>WA-337485</i>		17. INFORMANT <i>DAUGHTER MRS. THELMA WHALEN</i>		Address <i>CORRISVILLE, IND.</i> <i>MASONIC HOME</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Cholelithiasis that gave rise to immediate cause (a), stating the underlying cause lost</i> (c) <i>Generalized arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 Years</i> <i>10 Years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>SEPT. 16, 1968</i> , to <i>SEPT. 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>9/18/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Edwin L. Pierpont</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>9/18/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>EDWIN L. PIERPONT, M.D.</i>		22e ADDRESS <i>8224 LIBERTY RD - BALTO. 21207 MD.</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Sept. 21, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto. City Maryland</i>			
24. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Road Randallstown</i>		25a. REC'D BY REGISTRAR <i>SEP 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

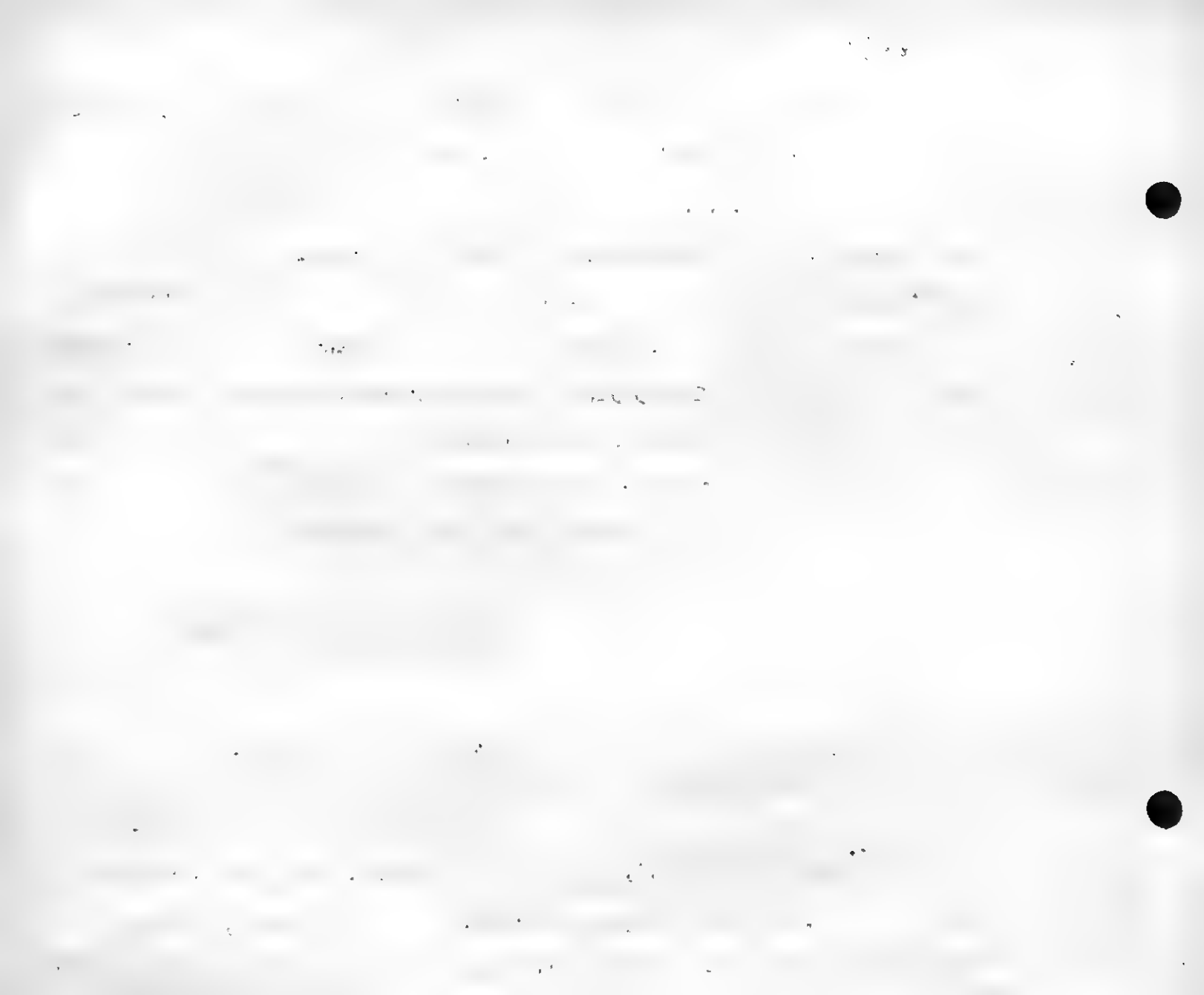


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VR 1-1-68
30M REV 11/68

12663		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12875	
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR
JOHN ERNEST PEACOCK					SEPTEMBER 28, 1968		3:25A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		CAUCASIAN		AUGUST 16, 1889		79 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		U.S.A.		BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD		VETERANS ADMIN HOSPITAL		PLUMBER			
13a. USUAL RESIDENCE (Where deceased lived, if institution an address on) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND				BALTIMORE		4513 PENN LUCY ROAD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
JOHN K PEACOCK		MARGARET SCHAFFER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
YES		WW I		CLINICAL RECORDS, VA HOSP, FT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE							WEEKS
DUE TO, OR AS A CONSEQUENCE OF HEART DISEASE							
Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause							
(b) PULMONARY HYPERTENSION AND ARTERIOSCLEROTIC							MONTHS
DUE TO, OR AS A CONSEQUENCE OF							
(c) CA OF THE LUNG WITH LIVER METASTASIS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
112X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that XX (this hospital) attended the deceased from 9/24/68, 19__, to 9/28/68, 19__, that XX (we) last saw the deceased alive on 9/28/68, 19__, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) did XX view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) MARIO J QUIROS, M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		9 28 68	
22e. ADDRESS							
VA HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		10-1-1968		LORRAINE CEMETERY		BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, 4107 WILKENS AVE, BALTO, MD				DATE OCT 3 1968		f Charles Judge	



12666

CERTIFICATE OF DEATH

12676

1 DECEASED NAME (Type or print) FRANCIS			First Middle Last J. FRANK PLUCIAK			2a. DATE OF DEATH Month Day Year 9/5/68			2b. HOUR 2:25P M		
3. SEX MALE			4 RACE WHITE			5 DATE OF BIRTH 9/24/95			6 AGE (' years last by) 72 YRS.		
7a BIRTHPLACE (State or foreign country) Baltimore, Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md		
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN			12b KIND OF BUSINESS OR INDUSTRY MUSICAL INSTRUMENT		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b COUNTY 13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 425 S. Ellwood Avenue		
14 FATHER'S NAME First Middle Last Francis Pluciak			15 MOTHER'S MAIDEN NAME First Middle Last Madeline MN: Bietler			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW I			16b SOCIAL SECURITY NO 216 10 94 12		
17 INFORMANT Helen Rodgers, Sister			17 ADDRESS 425 S. Ellwood Avenue			17 CITY CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 11 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS									YEARS		
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS									YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/25/68 , 19____, to 9/5/68 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/5/68 , 19____, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b SIGNATURE William Ann Orer M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/5/68		
22d PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 9/9/68			23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR			ADDRESS SCHIMMEL FUNERAL HOME			25a REC'D BY REGISTRAR SEP 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (see funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

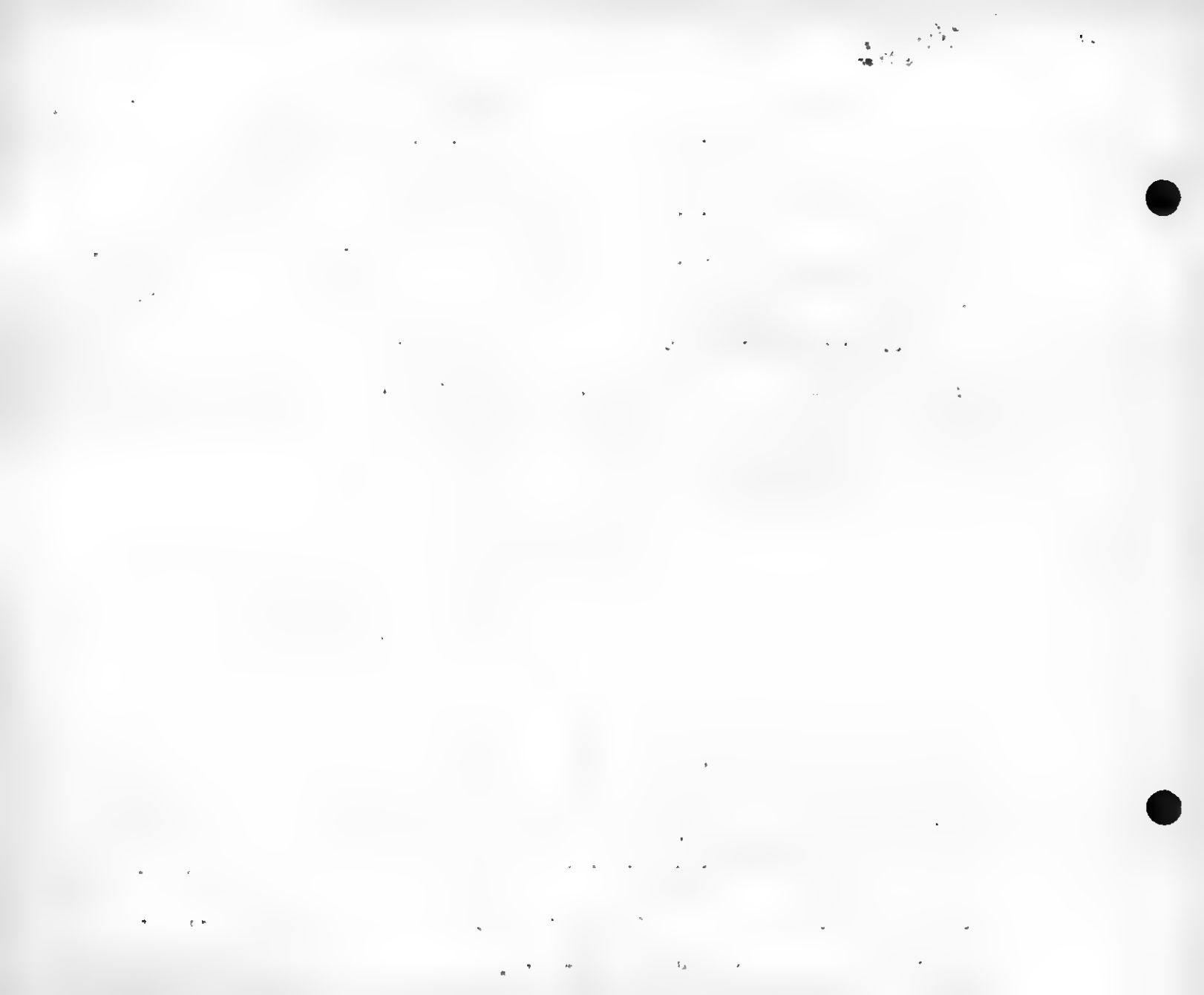
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12667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

126677

1 DECEASED NAME (Type or print) Myra Long Purcell			2a. DATE OF DEATH Month September Day 29 Year 68			2b. HOUR 9.00 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 5-11-1896		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1711 Earhart Road - 21221	
14 FATHER'S NAME First Middle Last Clarence Ravenscroft			15. MOTHER'S MAIDEN NAME First Middle Last Lulu Long						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 705 09 5805		17 INFORMANT Address Edwin Purcell 21 Lynnbrook Rd 21220					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 104									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/26/ , 19 68 , to 9/29/ , 19 68 , that (I) (we) last saw the deceased alive on 9/29/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Geodulo Paglinawan, Jr. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/29/68			
22d. PHYSICIAN'S NAME (Type) Geodulo Paglinawan, Jr. M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/2/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.			
24 FUNERAL DIRECTOR ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.				25a. REC'D BY REGISTRAR DATE OCT 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12668

12678

1. DECEASED-NAME (Type or print) First Middle Last Brenda Jeannette Purkey			2a. DATE OF DEATH Month Day Year Sept 8 1968		2b. HOUR 11 P M
3 SEX Female	4. RACE White	5. DATE OF BIRTH 11/1/40		6. AGE (In years last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hosp.		12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Howard	13c. CITY OR TOWN Marriottsville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Dogwood Road
14. FATHER'S NAME First Middle Last Wiley Purkey			15. MOTHER'S M.A.D.E.N. NAME First Middle Last Ella Bryant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO NONE		17. INFORMANT Address Rosewood Records Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Insufficiency 4-1 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 490 X (b) Acute Lobar Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 day					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Spastic paraplegia 6 - Grand mal seizure.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc. OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 6 , 19 68 , to Sept 6 , 19 68 , that (I) (we) last saw the deceased alive on Sept 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Remzi Demir M.D.		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED Sept 6/68	
22d. PHYSICIAN'S NAME (Type) Remzi Demir M.D.		22e. ADDRESS Rosewood St to Ho + Marriottsville, Md. 21111			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-10-68	23c. NAME OF CEMETERY OR CREMATORY ST Johns		23d. LOCATION (City or Town) (County) (State) Ellicott City Howard Md	
24. FUNERAL DIRECTOR John R. Slack		ADDRESS Ellicott City, Md.		25a. REC'D BY REGISTRAR SEP 10 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

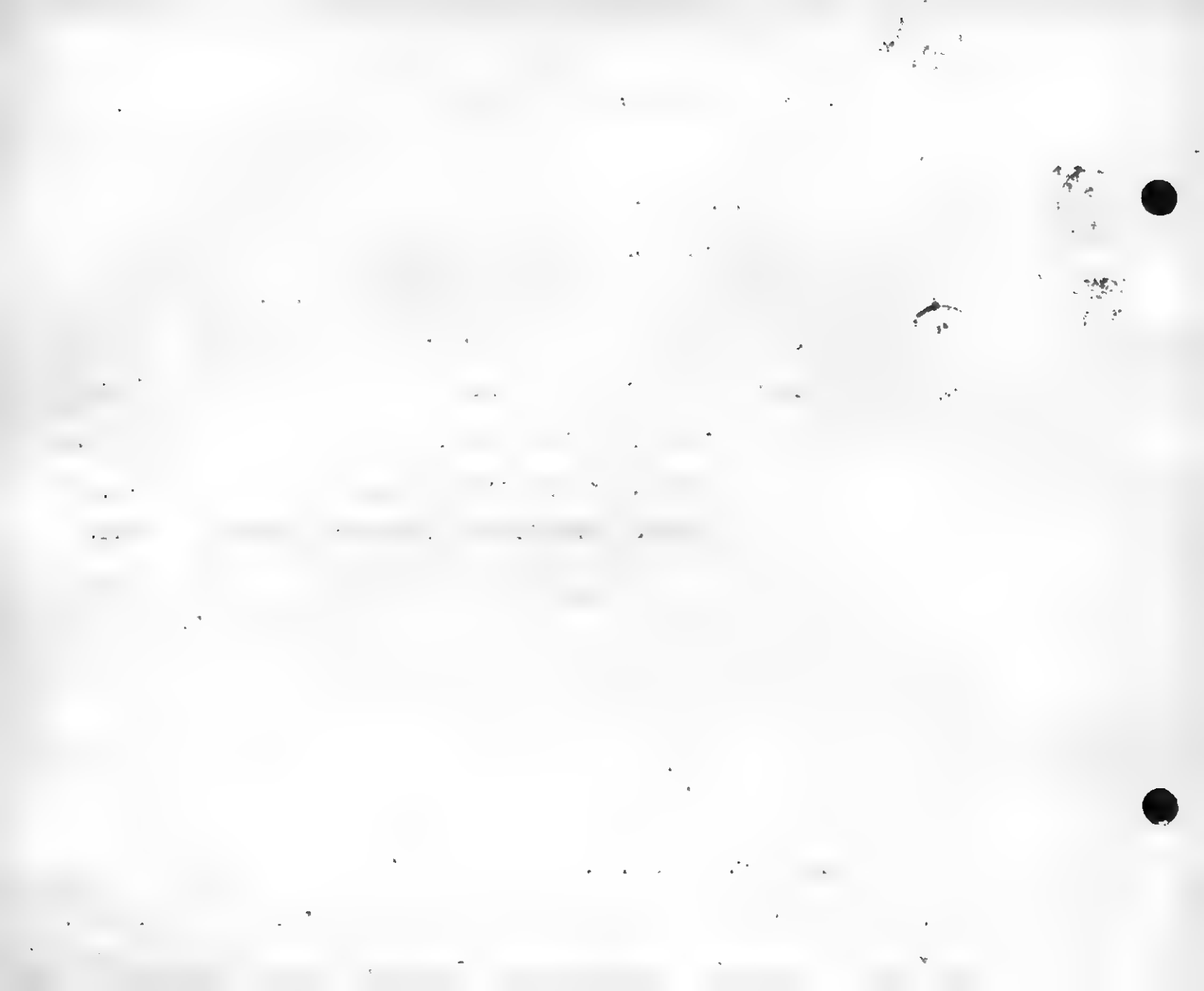
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 103-4
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 126679

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HARRY		First HARRY		Middle JOSEPH		Last PURVEY		2a. DATE OF DEATH Month 9 Day 20 Year 68			2b. HOUR 1:00PM		
3 SEX MALE		4 RACE NEGRO		5. DATE OF BIRTH 4/4/25			6 AGE (In years last birthday) 43 YRS		IF UNDER YEAR MONTHS 1 DAYS 10		IF UNDER 24 HRS HOURS 1 MIN 00		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md							
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL			12a. USUA. OCCUPATION (Kind of work done during most of work week, even if retired) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY					
13a. US. A. RESIDENCE (Where deceased lived, if institut on Res dence before admission) STATE MARYLAND		13b. COUNTY CALVERT		13c. CITY OR TOWN CHESAPEAKE BEACH		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P. O. BOX 636A					
14. FATHER'S NAME WILLIAM		First WILLIAM		Middle PURVEY		Last PURVEY		15. MOTHER'S MAIDEN NAME ETHEL		First ETHEL		Middle GROSS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> YES		(1 yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO. 213 22 13 73		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROGRESSIVE LIVER FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS			
5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) UPPER GASTROINTESTINAL BLEEDING										4 DAYS			
DUE TO, OR AS A CONSEQUENCE OF (c) LAENNEC'S CIRRHOSIS WITH ESOPHAGEAL VARICES										YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that Dr (this hospital) attended the deceased from 7/9/68 , 19__, to 9/20/68 , 19__, that he (we) last saw the deceased alive on 9/20/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Rodolfo G. Miro</i>		DEGREE RODOLFO G. MIRO, M. D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/20/68							
22d. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND											
23a. BURIAL CREMATION, REMOVAL, SPOULY BURIAL		23b. DATE 9-24-68		23c. NAME OF CEMETERY OR CREMATORY ST EDMONDS CHURCH CEMETERY			23d. LOCATION (City or Town) (County) (State) PRINCE FREDERICK, MD.						
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell</i>		ADDRESS PINKNEY SEWELL FUNERAL HOME		25a. REC'D BY REGISTRAR SEP 25 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Dr. Joseph Everett Quillen			2a. DATE OF DEATH 9 Month 22 Day 68 Year			2b. HOUR 5:30a M			
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 03-16-04		6. AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Ocean City, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Balto. Md. 21204		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cent.		12a. U.S. OCCUPATION (Kind of work done during most of work life, even if retired) Retired Dentist		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8511 Valleyfield Road	
14. FATHER'S NAME First Middle Last Joseph Hall Quillen			15. MOTHER'S MAIDEN NAME First Middle Last Mary Purdue						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <input checked="" type="checkbox"/> (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO 213-38-8237		17. INFORMANT Address Mrs. Elizabeth Quillen (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4367 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/15 , 19 68 , to 9/22 , 19 68 , that (I) did saw the deceased alive on 9/21 , 19 68 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) yes <input checked="" type="checkbox"/> (I) did not <input type="checkbox"/> view the body after death.									
22b. SIGNATURE M. N. Al-Mumayez				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/22/68			
22d. PHYSICIAN'S NAME (Type) M.N. Al-Mumayez				22e. ADDRESS GBMC 6701 N. Charles St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/25/68		23c. NAME OF CEMETERY OR CREMATORY Monte Marie		23d. LOCATION (City or Town) (County) (State) Towson, Balto Co., Md.			
24. FUNERAL DIRECTOR A.W. Jenkins & Sons Co.				ADDRESS 4905 York Road Balto., Md.		25. RECEIVED BY SEP 24 1968		25b. RECEIVED BY SIGNATURE Charles Judge	

1991

12671

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) Mamie Gertrude Rappold			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH Day Year 1968 MATED <input type="checkbox"/> 9 19 1968			2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH 19 July 1894	6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 1968 Sept 19 1968
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6E. Overlea Avenue 21206	
14 FATHER'S NAME First Middle Last Henry W. Morgan			15 MOTHER'S MAIDEN NAME First Middle Last Susan McManus			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 214 01 97908		17. INFORMANT ADDRESS Clarence J. Rappold 6E. Overlea Avenue		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis Cardiovascular Disease 1129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus (20 yrs?)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE John C. Hyle		M.D.		22b. DATE SIGNED 9-19-68		
EXAMINER'S NAME (Type) JOHN C. HYLE		ADDRESS (Street, city, town, or county) 7527 Bunker				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-23-1968	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Co. Md		
24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 6401 Belair Road 21236				25a. REC'D BY REGISTRAR DATE SEP 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon pages 1 and 2 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12672

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12682

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Elizabeth M. Renner			2a DATE OF DEATH Month 9 Day 1 Year 68			2b HOUR 6:30			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Sept. 15, 1889		6 AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at home		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Maryland		13b COUNTY —		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1500 E. 36th St.	
14. FATHER'S NAME First Middle Last George Schorr			15 MOTHER'S MAIDEN NAME First Middle Last Margaret Yaeger						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT Address Philip Brunner, Jr. 34 Joanna Way, Summit. N.J.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF ASCVD. Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 x 2 x 1									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/30/68 , 19 68 , to 9/1/68 , 19 68 , that (I) (we) last saw the deceased alive on 8/30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Robert J. Mahon				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 9/3/68			
22d PHYSICIAN'S NAME (Type) ROBERT J. MAHON, M.D.				22e ADDRESS 204 East Joppa Road Towson, Md. 21201					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 9/4/68		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Parkville, Md.			
24 FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road.				25a REC'D BY REGISTRAR DATE SEP 6 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12673

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12683

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> September 18 1968		2b HOUR M
RUTH EILEEN REPERT							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year
Female	Cau.	Aug. 28, 1920		48 YRS			September 18 1968
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
West Virginia		U.S.A.				Baltimore Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson		St. Joseph Hosp.		Sect'y.		U.S.A.	
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore		Lutherville		13e STREET AND NUMBER	
						18 Dunwich Road	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
William A. Fleming					Nina Marteny		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		236-12-6139		Mr. Ralph P. Reppert, Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause lost							
(b)							
DUE TO, OR AS A CONSEQUENCE OF.							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION: Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED			
Charles F. O'Donnell		Charles F. O'Donnell, M.D.		9/18/68			
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		Sept. 21, 1968		Grace Methodist Cemetery		Cookeysville, Baltimore, Md.	
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland				DATE SEP 20 1968		Charles Judge	



12674

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12684

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) MARY		A. ROBEY		2. DATE AND HOUR OF DEATH September 3, 1968		1:30 P. ^{M.}	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BALTIMORE COUNTY FULL NAME OF HOSPITAL OR INSTITUTION SUMMIT NURSING HOME 23 Smithwood Ave. Catonsville, Md. 21228				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER Charles & 33rd Street							
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1886		9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. Robey				14. MOTHER'S MAIDEN NAME Annie Plecher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-07-8543		17. INFORMANT Elizabeth Zirwes-6617 Kilmarnoch Rd # 8			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of Ovary with Multiple Metastases (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23A. SIGNATURE <i>Ronald N. Kornblum</i> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED September 3, 1968	
23C. PHYSICIAN'S NAME (Type) Ronald N. Kornblum, M.D.				23D. ADDRESS 700 Fleet St. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) 9-5-68 Burial	24B. DATE 9-5-68	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1968		25B. NAME OF REGISTRAR <i>Charles Judge</i>		25C. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts. Ave		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12673

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12585

1 DECEASED-NAME (Type or print) Harvey Miller Robinson			2a DATE OF DEATH Month Sept Day 9 Year 1968			2b HOUR 10 A-M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH Sept 11-1905		6 AGE (In years lost birthday) 62 YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) St Mary Co Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Likesville Baltimore Md		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 304 Upland Rd Baltimore Md 21208		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY Clark Railroad Clerk			
13a U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Florida		13b COUNTY 5209 Grant Ave Satellite Beach		13c CITY OR TOWN Satellite Beach		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5209 Grant Ave	
14 FATHER'S NAME First Middle Last Henry Robinson			15 MOTHER'S MAIDEN NAME First Middle Last Nellie Gracie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. ?		17 INFORMANT Mrs Harvey Robinson 5209 Grant Ave Satellite Beach, FLA 32935				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost generalized arteriosclerosis 6 yrs (b) generalized arteriosclerosis 6 yrs DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis 6 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of lung; Cerebral Vascular Accidents									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/12/68 , to 9/9/68 , that (I) (we) last saw the deceased alive on 8/12/68 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W H Foard		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 9/9/68			
22d. PHYSICIAN'S NAME (Type) W. H Foard MD		22e ADDRESS 25 N. Main St Manassas Md 2102							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 9/12/68		23c NAME OF CEMETERY OR CREMATORY Wt. Zion		23d LOCATION (City or Town) (County) (State) Free Land Md 2102			
24. FUNERAL DIRECTOR Erning Byers - 8725 Liberty Road									
VR 100 30M REV 1/68				25a REC'D BY REGISTRAR SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



12676

CERTIFICATE OF DEATH

12686

1 DECEASED-NAME (Type or print) Mrs. MARY Evans ROBINSON			2a. DATE OF DEATH Month 9 - Day 27 - Year 1968			2b. HOUR 6:35 PM					
3 SEX F		4 RACE C		5. DATE OF BIRTH 3-10-1892		6. AGE (In years lost birthday) 76 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) DEAL ISLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.					
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) DOMESTIC			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2321 East Preston St.					
14. FATHER'S NAME First JOHN Middle EVANS Last —				15. MOTHER'S MAIDEN NAME First SARAH Middle DASHIELDS Last —							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) —		16b. SOCIAL SECURITY NO. 217-01-0136		17. INFORMANT Address Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE UREMIA										one day	
DUE TO, OR AS A CONSEQUENCE OF (b) NEPHROSCLEROSIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last —											
DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIO SCLEROSIS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 446. Minimal pulmonary tuberculosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 10 Day 27 Year 1968 P.M. —			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No — City or Town — County — State —						
22a. I certify that (I) (this hospital) attended the deceased from 8-20-1962 to 9-27-1968 , that (I) (we) last saw the deceased alive on 9-27-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Newcomer										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.										22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct 2 / 68		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem		23d. LOCATION (City or Town) (County) (State) Westport Md.					
24. FUNERAL DIRECTOR Joseph T. Elshen				ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12677

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12687

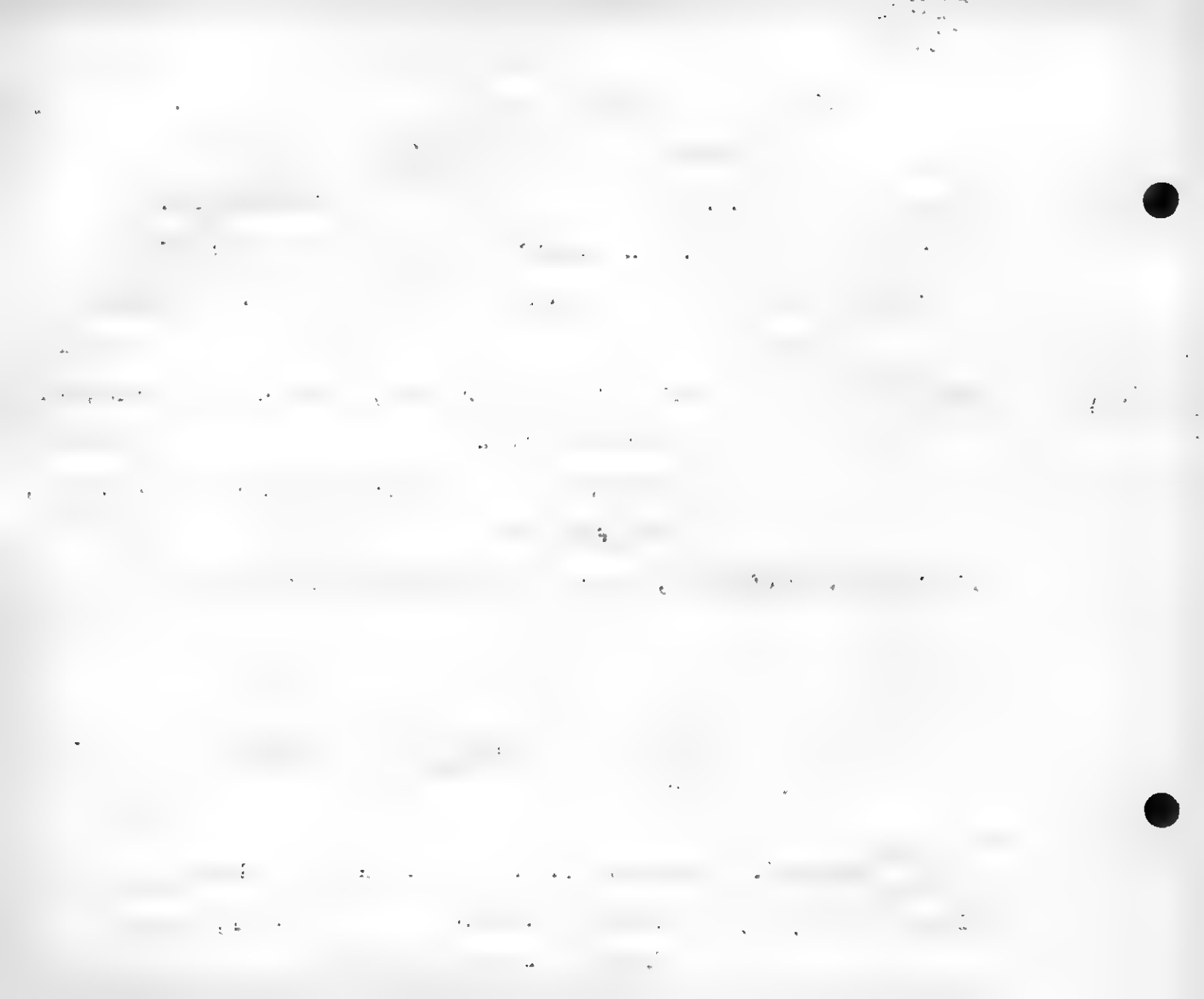
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Bertha E. Rochford</i>			2a. DATE OF DEATH Month <i>Sept.</i> Day <i>8</i> Year <i>1968</i>			2b. HOUR <i>9:45AM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 25, 1889</i>		6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>					
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sharon La Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Lutherville</i>		13d. INSIDE CITY LHM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1211 Longford Road</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>Wilson</i> Last <i>?</i>			15. MOTHER'S MAIDEN NAME First <i>Lula</i> Middle <i>?</i> Last <i>?</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>220-46-6079</i>			17. INFORMANT <i>Mrs. George Schnabel</i>			Address <i>(Same)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>YEARS</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. <i>5 min</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>											
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>—</i> <i>—</i> <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>—</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <i>8-30</i> , 19 <i>68</i> , to <i>9-7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frank G. Kuehn M.D.</i>						DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9-9-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>FRANK G. KUEHN, M.D.</i>						22e. ADDRESS <i>721 MEDICAL ARTS BLDG.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/11/68.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Nat. Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>						25a. REC'D BY REGISTRAR <i>SEP 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <div>12672</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div style="text-align: right;">12688</div>																															
1. DECEASED-NAME (Type or print)				First JOHN				Middle NELSON				Last ROFF				2a. DATE OF DEATH				2b. HOUR											
												Month 9				Day 30				Year 68				5:50A M							
3 SEX MALE				4 RACE WHITE				5 DATE OF BIRTH 2/16/92				6 AGE (In years lost birthday) 76 YRS.				IF UNDER 1 YEAR MONTHS				IF UNDER 24 HRS. HOURS MIN.											
7a BIRTHPLACE (State or foreign country) MARYLAND				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH BALTIMORE COUNTY, Md																			
10 CITY OR TOWN OF DEATH FORT HOWARD				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. HM. HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, and if retired) AUTO TITLE & TAG SERVICE				12b KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY BALTIMORE				13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 224 E. 22nd Street															
14. FATHER'S NAME				First HARRY ROFF				Middle				Last				15 MOTHER'S MAIDEN NAME				First ALICE				Middle HALL				Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES				(If yes give year or dates of service) WW I				16b SOCIAL SECURITY NO 217 32 88 69				17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE, MASSIVE																RECENT															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																(b) RUPTURE ANASTOMOSIS ABDOMINAL AORTA AND NYLON PROSTHESIS,															
DUE TO, OR AS A CONSEQUENCE OF																(c) BRONCHOPNEUMONIA															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PLEURAL EFFUSION BILATERAL, RECENT. ARTERIOSCLEROTIC HEART DISEASE, OLD																															
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)				21f LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/20/68 , 19____, to 9/30/68 , 19____, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 9/30/68 , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																															
22b SIGNATURE <i>George C. McElpatrick</i>												DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 9/30/68															
22d PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.												22e ADDRESS VAH FORT HOWARD, MARYLAND																			
23a BURIAL, CREMATION, (Type or print) BURIAL				23b DATE 10/3/1968				23c NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY				23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND																			
24. FUNERAL DIRECTOR ADDRESS MITCHELL WIDEFIELD FUNERAL HOME 6500 York Road, Baltimore, Md.																25a REC'D BY REGISTRAR DATE 3 1968				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 for the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

12679

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Middle Last		ADELAIDE PFEIFFER ROGERS		2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
3 SEX Female		4. RACE Cau.		5. DATE OF BIRTH July 20, 1893		6. AGE (In years) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		2c. DATE PRONOUNCED DEAD September 9 1968	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armstrong Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		2d. HOUR 3:30 PM	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		3d. INSIDE CITY, M-15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3600 Durley Lane	
14. FATHER'S NAME First Middle Last Samuel Clarence Padgett		15. MOTHER'S MAIDEN NAME First Middle Last Mamie Roberts		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 213-28-1193		17. INFORMANT Jean P Reitz, Belfast Rd., Sparks, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bacterial Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fracture of Supracondyle Rt Femur</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 Days</u>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>		19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture of Rt Femur</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>11:30 6/19/68</u>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>11:30 6/19/68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 19) <u>Apparently Fell in Room</u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>At Work</u>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Nursing Home</u>	
21f. LOCATION Street or R.F. No. City or Town County State <u>812 Regester Ave. Baltimore</u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED <u>9/10/68</u>		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>Charles F. O'Donnell, M.D.</u>		22d. ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204	
25a. REC'D BY REGISTRAR DATE SEP 11 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>		25d. REGISTRAR'S ADDRESS <u>1050 York Road Towson, Maryland 21204</u>		25e. REGISTRAR'S PHONE <u>1050 York Road Towson, Maryland 21204</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12680
12680
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) LENA ROSEN			First Middle Last			2a. DATE OF DEATH Month Day Year SEPTEMBER 16, 1968			2b. HOUR 9:30A.M.		
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH MARCH 10, 1876			6 AGE (In years last birthday) 92 YRS.		
7a BIRTHPLACE (State or foreign country) RUSSIA			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE		
10 CITY OR TOWN OF DEATH PIKESVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) STATE MARY LAND			13b COUNTY BALTIMORE			13c CITY OR TOWN BALTIMORE			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last MORRIS JANOWSKY			15. MOTHER'S MAIDEN NAME First Middle Last SARAH ?			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) NO			16b SOCIAL SECURITY NO		
17. INFORMANT Address MRS. MILDRED FRIEDLANDER, 3305 NORTHMONT RD.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4129 DUE TO, OR AS A CONSEQUENCE OF (b) none DUE TO, OR AS A CONSEQUENCE OF (c) none			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4222 none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1959 , to Sept 16, 1968 , that (I) (we) last saw the deceased alive on Sept 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Manuel Levin			22c. DATE SIGNED 9/16/68			22d PHYSICIAN'S NAME (Type) DR. MANUEL LEVIN			22e ADDRESS 6101 PARK HEIGHTS AVENUE		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9-17-68			23c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			25a. REC'D BY REGISTRAR SEP 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-333. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12691

1 DECEASED-NAME (Type or Print) <i>Kenneth James Rothe</i>			2a DATE KNOWN OF DEATH Month <i>September</i> Day <i>16</i> Year <i>1968</i>			2b HOUR <i>3:30 PM</i>		
3 SEX <i>M</i>	4 RACE <i>CAUC.</i>	5 DATE OF BIRTH <i>1-25-52</i>	6 AGE (in years last birthday) <i>16</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <i>September</i> Day <i>16</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>Ill.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i>		
10. CITY OR TOWN OF DEATH <i>Towson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>GR. BALTO. Med. Center</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital, give street address) STATE <i>Md.</i>		13b COUNTY <i>BALTO.</i>		13c CITY OR TOWN <i>Towson</i>		13d INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>549 Piccadilly Rd.</i>
14. FATHER'S NAME First <i>KENNETH</i> Middle <i>NMN</i> Last <i>ROTHE</i>			15 MOTHER'S MAIDEN NAME First <i>Genevieve</i> Middle <i>DeVinney</i> Last <i>DeVinney</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16b SOCIAL SECURITY NO <i>213-58-3402</i>		17. INFORMANT <i>mother</i>		ADDRESS <i>549 Piccadilly Rd. 21204</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY <i>952</i> IMMEDIATE CAUSE (a) <i>Strangulation</i> DUE TO, OR AS A CONSEQUENCE OF <i>from hanging</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 ALTOPIST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or R.F.D. No City or Town County State <i>549 Piccadilly Rd. Towson BALTO Md.</i>				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from, Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <i>9/16/68</i>		
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
			ADDRESS (Street, city, town or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>9/19/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Roselawn Mem. Park Co.</i>		23d LOCATION (City or Town) (County) (State) <i>Madison, Wisconsin</i>		
24 FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson 1050 York Rd. 21204</i>				25a REC'D BY REGISTRAR <i>SEP 19 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

12682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12692

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
CHARLES RUDOLPH ROUSE, Sr.					SEPTEMBER 30, 1968		10:00 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		JANUARY 1, 1899		69 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		ST. JOSEPH HOSPITAL		Retired Lawyer		Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		349 TUNBRIDGE RD. #21212			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Rudolph R. Rouse					Bertha Mueller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
Yes		WIT				Mrs. Bessie M. Rouse			(Same)
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant mesothelioma of the right pleura									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
163									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from September 6, 1968, to September 30, 1968, that (I) (we) last saw the deceased alive on September 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Christina Feliciano, M.D.								22c. DATE SIGNED 10-1-68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS	
Christina Feliciano, M.D.								7620 York Rd. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/4/68		New Cathedral		Baltimore Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE OCT. 3, 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Five Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

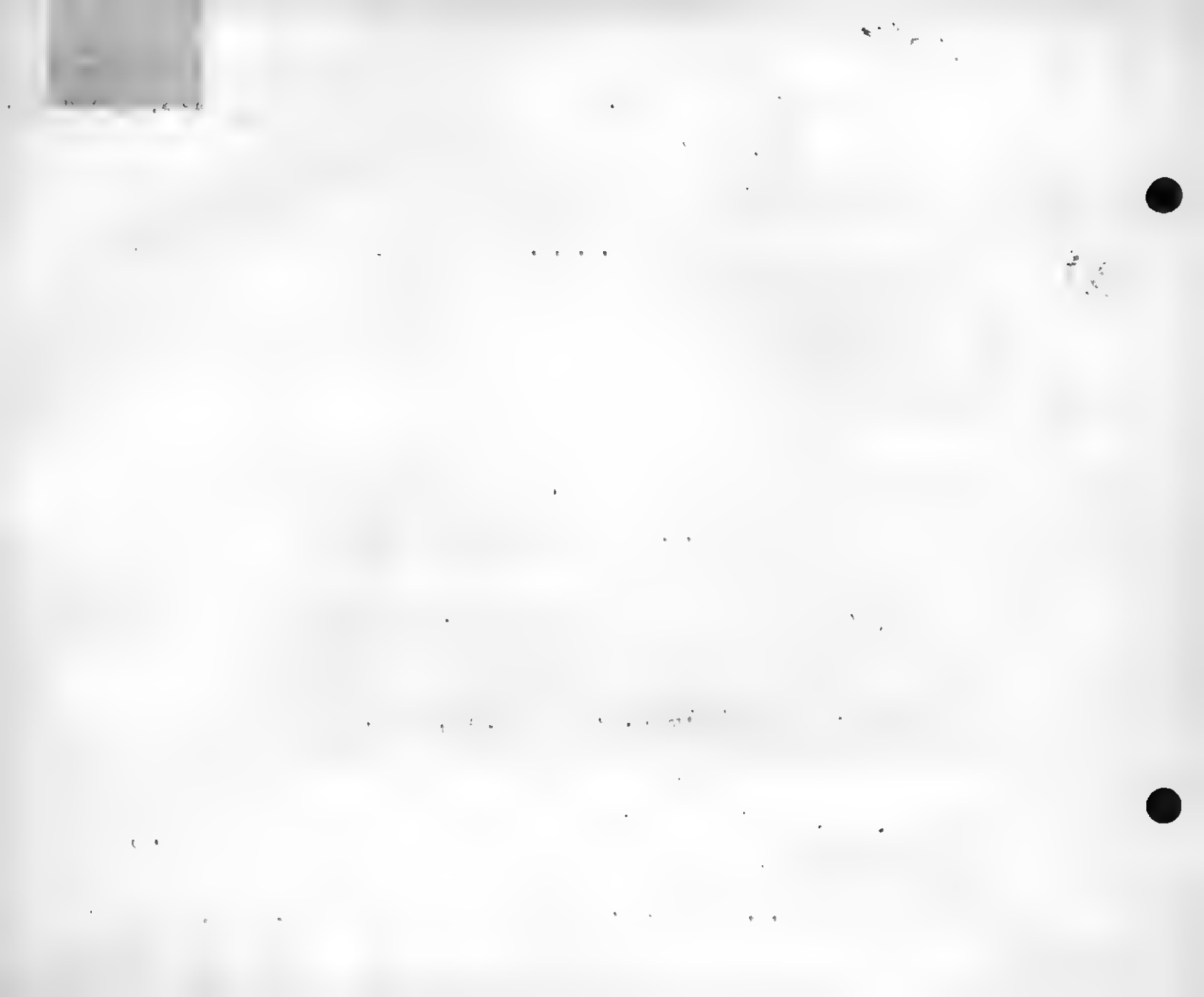
TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12683

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <i>Catherine Leta Royston</i>		First <i>LCLISE</i> Middle <i>Royston</i> Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <i>Sept. 2, 1968</i> 1:45		2b HOUR <i>1:45</i>	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>June 2, 1888</i>	6 AGE (in years and months) <i>80</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 19 <i>19</i>	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore County</i>	
10 CITY OR TOWN OF DEATH <i>Towson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>G.B.M.C.</i>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Towson</i>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <i>William Howard</i>		First Middle Last		15 MOTHER'S M A DEN NAME <i>Indiana Elizabeth Holland</i>		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOC AL SECURITY NO (If yes, give no. or dates of service) <i>156-20-9111</i>		17 INFORMANT <i>Family records</i>		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Lung Congestion & Edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>C.V.A. (Fracture Right Femur)</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION <i>July 6, 1968</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture Right Hip</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month Day Year HOUR A.M. <i>July 4, 1968</i> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, or other office building, etc.) <i>8703 Lock Bend Drive</i>		21f LOCATION Street or R.F.D. No. City or Town County State <i>Towson, Maryland 21234</i>			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William A. Pillsbury</i>		EXAMINER'S NAME (Type) <i>William A. Pillsbury</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>Sept. 3, 1968</i>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Sept. 4, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Poplar Grove Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Cockeysville, Maryland</i>	
24 FUNERAL DIRECTOR <i>John Burns Son, Towson, Md.</i>				25a REC'D BY REGISTRAR DATE <i>SEP 6 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

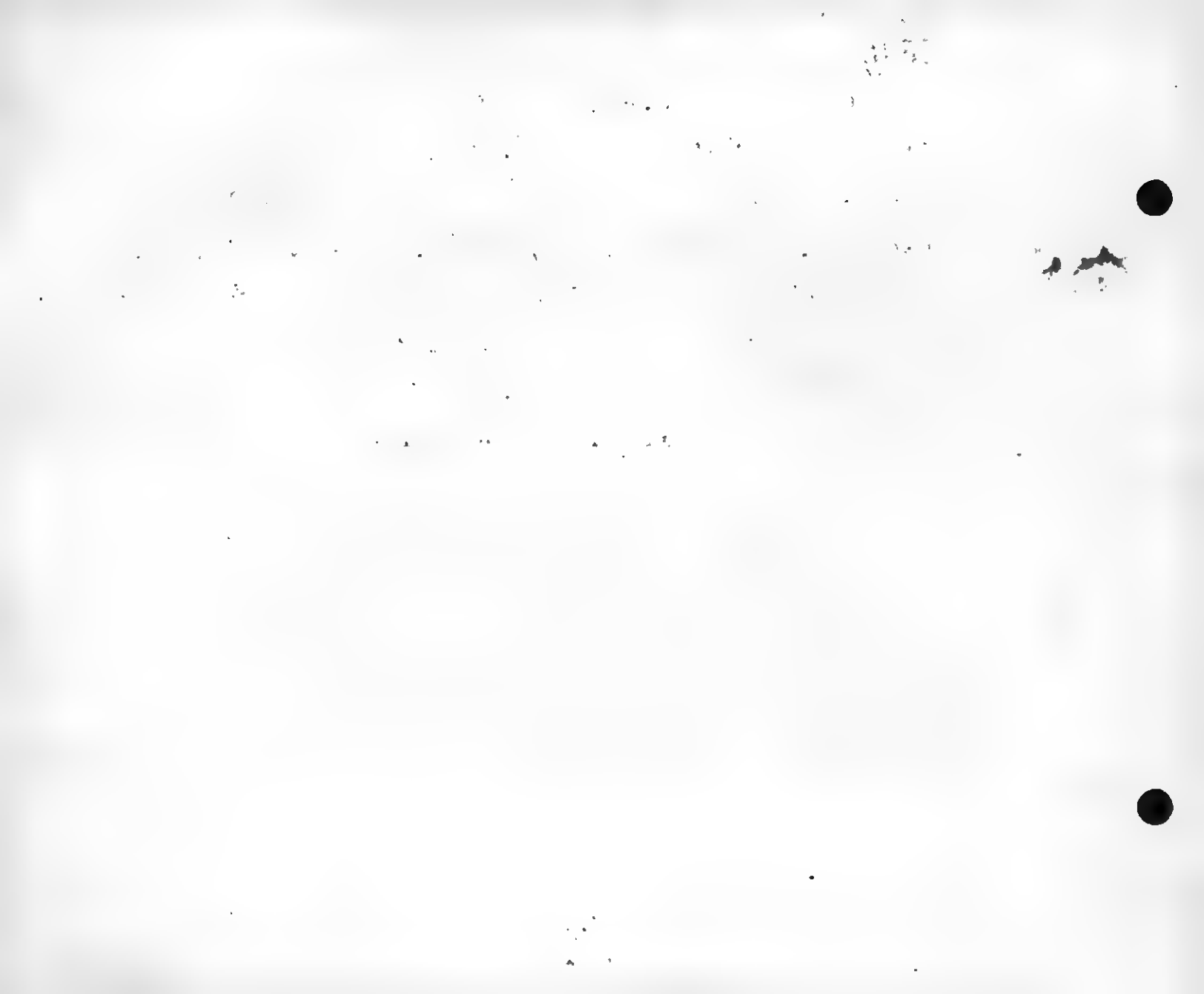
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

12684

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1-2-3-1
CERTIFICATE OF DEATH

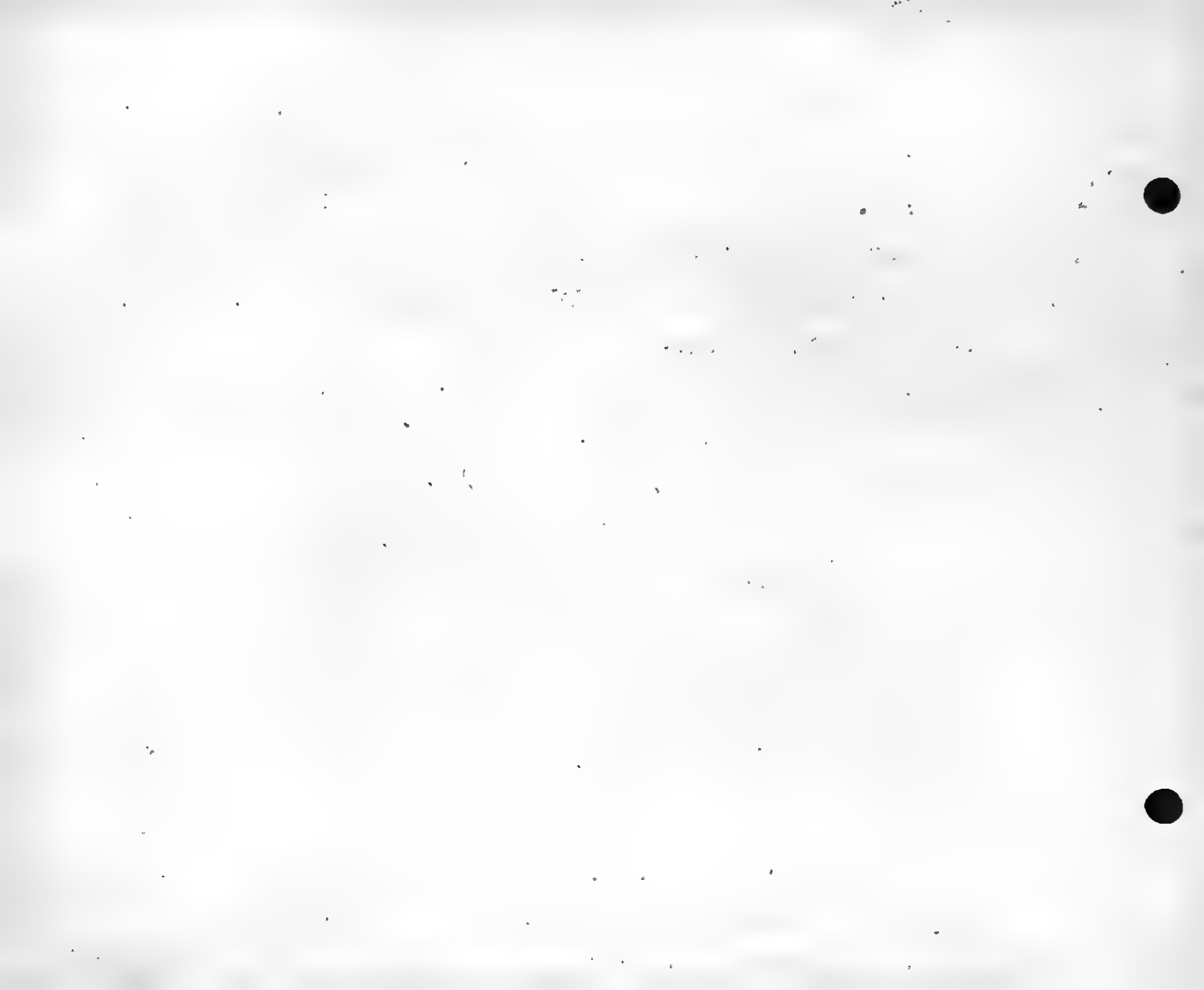
1. DECEASED-NAME (Type or print) ROBERT JAMES RUST			2a. DATE OF DEATH Month 9 Day 18 Year 68			2b. HOUR 7:35 am			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 19, 1923		6. AGE (In years last birthday) 45 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO., MED CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) MGR. & DISPATCHER		12b. KIND OF BUSINESS OR INDUSTRY MOVING CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 508 FAIRMONT AVENUE	
14. FATHER'S NAME First Middle Last ROBERT RUST			15. MOTHER'S M A DEN NAME First Middle Last THERESA MULLEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT FAMILY RECORDS		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/18/68 , 19 68 , to 9/18 , 19 68 , that (I) (we) last saw the deceased alive on 9/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE WM. YEH		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/18/68			
22d. PHYSICIAN'S NAME (Type) WM. YEH		22e. ADDRESS							
23a. BURIAL, CREMATION, etc. BURIAL		23b. DATE SEPT. 21, 1968		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.			
24. FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson		25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year			2b HOUR
Mollie			G.		Sadler		Sept. 23 1968			M		
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		Aug. 7, 1885			83 YRS.					
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland			USA					Baltimore County Mo				
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				2a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
(Catonsville)				Summit Nursing Home								
13a U.S.A. RESIDENCE (Where deceased lived, if instit in Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland				--		Baltimore		YES		901 St. Paul St.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last			
George			W.		Sadler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address						
			-			Summit Nursing Home, 98 Smithwood Ave.						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fracture, @ Hip</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD + senility</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
none												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
none												
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>14 Aug, 1968</u> , to <u>23 Sep, 1968</u> ; that (I) (we) last saw the deceased alive on <u>23 Sept 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>W. K. Gallager, Jr., M.D.</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>23 September 68</u>				
22d. PHYSICIAN'S NAME (Type) <u>W. K. Gallager, Jr., M.D.</u>						22e. ADDRESS <u>6630 Baltimore National Pike 21228</u>						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			9/25/68		New Cathedral			Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Witzke, 4101 Edmondson Ave., 21229						SEP 24 1968		<u>J. Santos Jr.</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

12686

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12896

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last JOHN FRANK SADOWSKI			2a. DATE OF DEATH Month Day Year September 16, 1968		2b. HOUR 10:20 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH July 26, 1894		6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Postman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Mail
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 128 N. Belnord Avenue	
14. FATHER'S NAME First Middle Last Joseph Sadowski		15. MOTHER'S MAIDEN NAME First Middle Last Cecilia Dekowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW I		16b. SOCIAL SECURITY NO 6-44-3580	17. INFORMANT Address Miss Agnes Sadowski, 128 N. Belnord Av		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF <u>urinary tract infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 177X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1968</u> to <u>Sept 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James H. Hamed</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 9/17/68	
22d. PHYSICIAN'S NAME (Type) JAMES H. HAMED MD.		22e. ADDRESS 204 E. JOPPA ROAD, V1204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/19/68	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

12687

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12687

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Louise Fisher Sadtler			2a DATE OF DEATH 9 Month 14 Day 68 Year 3:15a 2b HOUR	
3 SEX Female	4 RACE Cau	5. DATE OF BIRTH 6-11-11		6. AGE (In years birthday) 57 YRS
7a BIRTHPLACE (State or foreign country) BALTO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO, Md	
10 CITY OR TOWN OF DEATH BALTO.MD.	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Balto.Med.Cent.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At Home	12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md	13b COUNTY BALTO	13c CITY OR TOWN BALTO	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4509 Liberty Heights Ave
14. FATHER'S NAME First Middle Last Edward AILL Sadtler		15. MOTHER'S MAIDEN NAME First Middle Last Fisher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. -	17 INFORMANT Address Emma F. Sadtler - Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2001				
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (he she) attended the deceased from 8/1 , 1968 , to 9/14 , 1968 , that (I) (we) last saw the deceased alive on 9/14 , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE D. Corralis MD		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c DATE SIGNED 9-14-68	
22d. PHYSICIAN'S NAME (Type) D. Corralis		22e. ADDRESS GBMC 6701N. Charles St.		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-17-68	23c. NAME OF CEMETERY OR CREMATORY LORRAINE Cemetery	23d LOCATION (City or Town)	(County) (State)
24. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Heights	25a. REC'D BY REGISTRAR SEP 17 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge



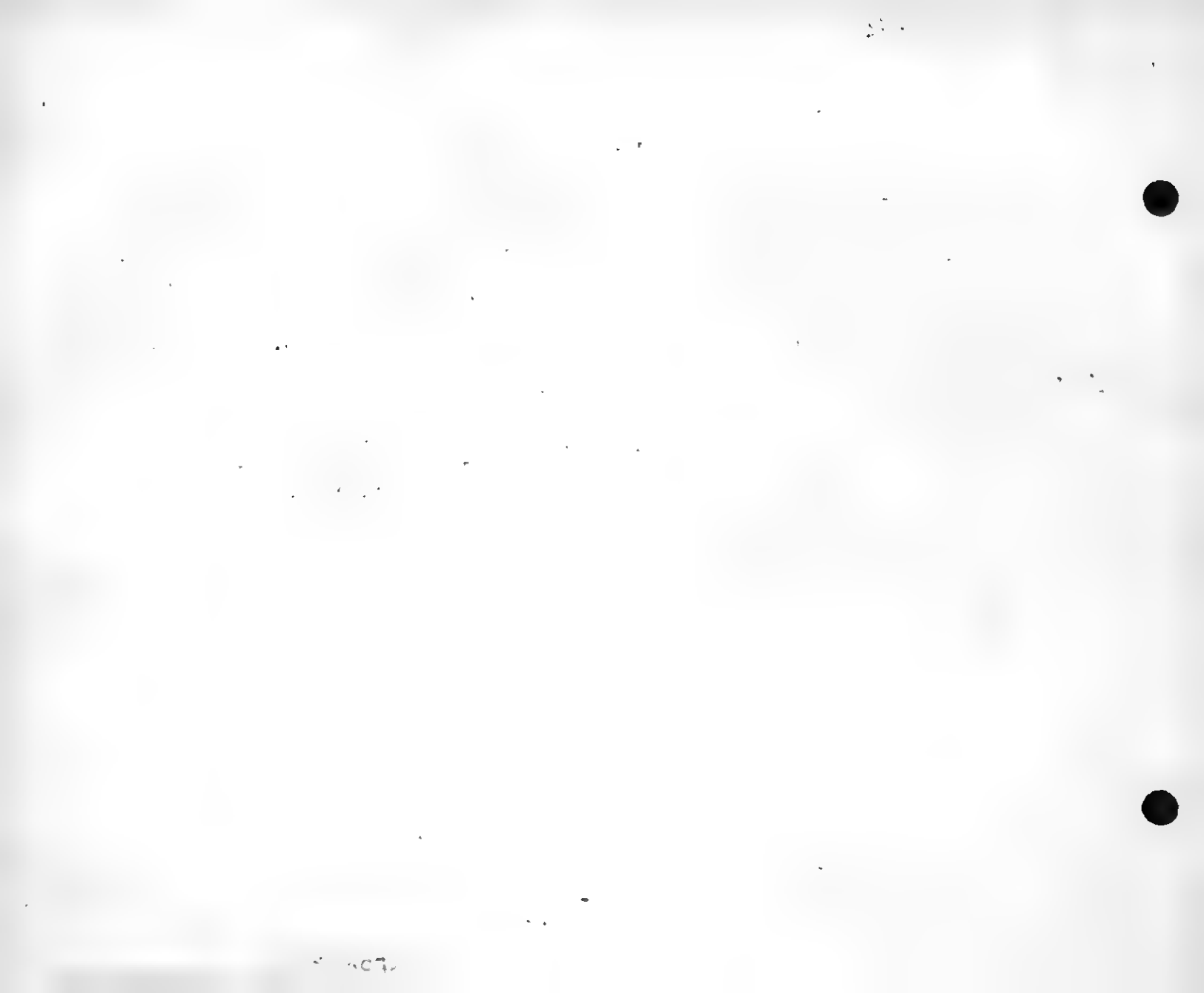
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12688

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12698
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Walter Eugene Sanders			2a. DATE OF DEATH Month Day Year 9 17 68		2b. HOUR 12:10 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH Oct. 19, 1913		6 AGE (In years lost birthday) 54 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Baltimore Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Co. Md.		
10. CITY OR TOWN OF DEATH Glen Arm	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wagon Wheel Rd.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Computer Programmer	12b. KIND OF BUSINESS OR INDUSTRY Martin Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Glen Arm	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Wagon Wheel Road	
14. FATHER'S NAME First Middle Last Joseph H. Sanders		15. MOTHER'S MAIDEN NAME First Middle Last Elizabett Foxwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 212-03-0936	17. INFORMANT Wife Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon (Rectosigmoid)</u> 1540 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>With metastasis to pelvis etc</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1968</u> , to <u>Sept. 17, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Caroline A. Chandler M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Sept. 17, 1968	
22d. PHYSICIAN'S NAME (Type) Caroline A. Chandler		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9/17/68	23c. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD U.S.M.D.		23d. LOCATION (City or Town) (County) (State) 37 S. Greene St.	
24. FUNERAL DIRECTOR Cook Funeral Home		25a. REC'D BY REGISTRAR DA. SEP 25 1968		25b. REGISTRAR'S SIGNATURE J. Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
William Edward Schackert Sr.						Sept. Month 22 Day 68 Year			7:30					
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		White		May 20, 1901			67 YRS.							
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U.S.A.						Baltimore					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph's Hospital			Retired			Behn, Steel					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Baltimore						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2800 Upridge Court Apt. C		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
John M Schackert			Katherine A Sapp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address					
No			213-09-2794			Mrs Anna M Schackert			Same					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Myocardial Infarction														
4109														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														
(b) Arteriosclerotic Cardiovascular Disease														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
7-11														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1968, to Sept. 22, 1968, that (I) (we) last saw the deceased alive on Sept. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Camilo Tomboc DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Sept. 22, 1968					
22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M. D.						22e. ADDRESS 7620 York Road Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			9/25/68			Oaklawn			Baltimore, Maryland					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc. Baltimore, Maryland									DATE SEP 24 1968			J. Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

12690

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

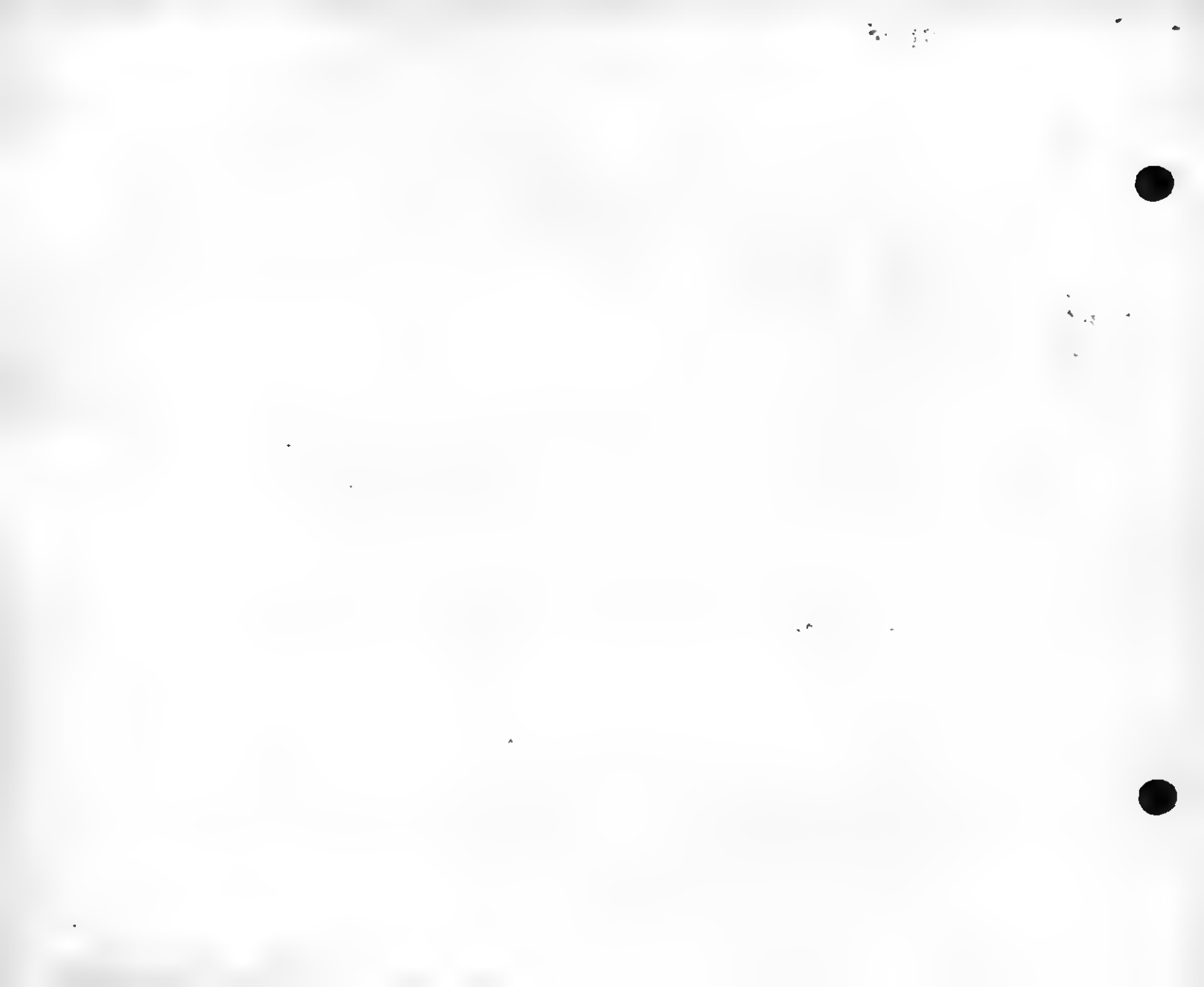
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. <input type="checkbox"/> Month Day Year			2b HOUR		
Hamilton			A. Schmidt Sr			DEATH MATED <input type="checkbox"/> Sept 18 1968			1:19		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	White	Nov 25 1916	51 YRS					Sept 18 1968			2 A M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Baltimore Md		U S A				Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp to give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			St Joseph Hospital DUA			Salesman			Auto		
13a USLA RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER			
Md			Balto	Overlea				14 Walnut Avenue 2106			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Christopher Schmidt			Clara F. Schwarz								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
Yes			World War II 217-09-7015			F. Odell Schmidt			14 Walnut Ave Balto Md 21206		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Sudden</u>											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
T-2-1											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			Charles F. O'Donnell, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			9/18/68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			Sept 21 1968		Oak Lawn Cemetery			Eastern Ave Blvd Balto Md			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAR			25b REG. STRAR'S SIGNATURE		
DIPPEL BROS INC			7110 BELAIR ROAD			SEP 19 1968			Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12695									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Anna					Schunick	Sept 22 1968		3 P	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS	
Female		White		Dec 22, 1900		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Baltimore Md		USA				Baltimore Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			3209 Mayfair Rd			Housewife		at Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER	
Maryland			Baltimore			YES		3209 Mayfair Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
Louis					Gross	Esther			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			21B-34-2148			Samuel Schunick - 3209 Mayfair Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis									
1820 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of endometrium									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF 4 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 2/19/67									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcin. Endometrium									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year 1968									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC									
21e. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 7/15, 1966, to 9/22, 1968, that (I) (we) lost saw the deceased alive on 9/22/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 22c. DATE SIGNED 9/24/68									
22d. PHYSICIAN'S NAME (Type) I S. ZINBERG 22e. ADDRESS 4000 W. Northern Parkway									
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE Sept 25/68 23c. NAME OF CEMETERY OR CREMATORY Beth Tfilah 23d. LOCATION (City or Town) (County) (State) Woodlawn, Md									
24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 26. DATE SEP 26 1968									
26. DATE SEP 26 1968 26b. REGISTRAR'S SIGNATURE J Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

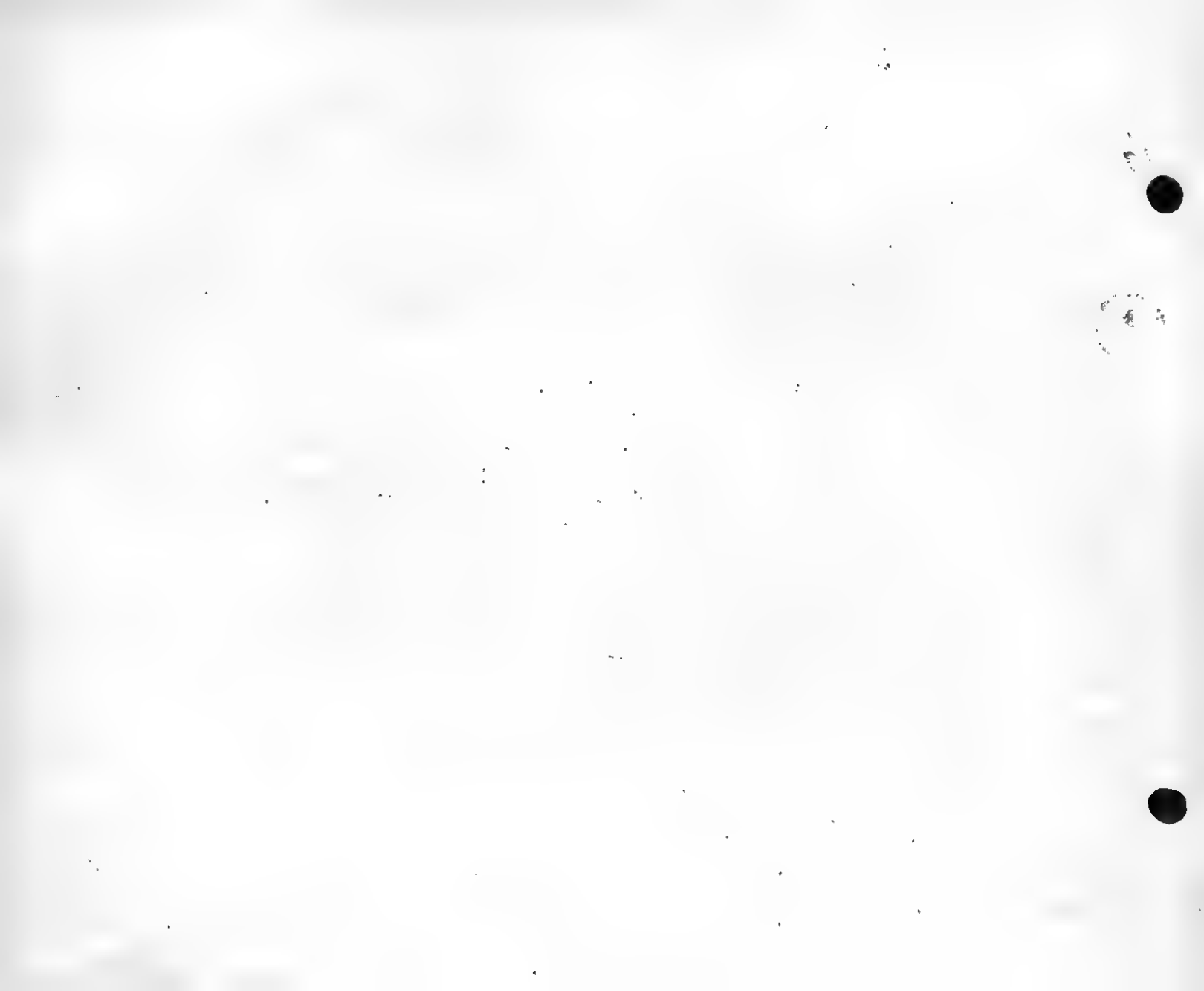
12697

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12702

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Bernhard J. Schwarting</i>			2a DATE OF DEATH Sept. Month 7 Day 68 Year			2b HOUR 9 A. M.					
3 SEX <i>Male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>January 30, 1892</i>		6 AGE (In years last birthday) <i>76</i> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Pova</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md					
10 CITY OR TOWN OF DEATH <i>Reisterstown</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>30 Main Street</i>			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Carpenter</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>			13b COUNTY <i>Balto.</i>		13c CITY OR TOWN <i>Reisterstown</i>		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>30 Main Street</i>		
14 FATHER'S NAME First Middle Last <i>George W. Schwarting</i>				15 MOTHER'S M A D E N NAME First Middle Last <i>Anna Dutler</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i> (If yes, give year or dates of service) <i>WW I</i>				16b SOCIAL SECURITY NO <i>219-07-2198</i>		17 INFORMANT Address <i>Mr. William B. Schwarting Sykesville, Md.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>41</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cardiovascular diseases</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <i>short interval years</i> (b) <i>interior</i> (c) <i>diseases</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-1960</i> to <i>9-7-1968</i> , that (I) (we) last saw the deceased alive on <i>8-7-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>James H. Saffell</i>				DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>9-9-68</i>			
22d PHYSICIAN'S NAME (Type) <i>James H. Saffell MD</i>				22e ADDRESS <i>Reisterstown Md</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Sept. 10, 68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>				23d. LOCATION (City or Town) <i>Pikesville, Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i>				ADDRESS <i>Reisterstown, Md.</i>				25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12693

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12703

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR		
JOHN			L. SCHWEIKART			Sept. 24			1968			1:20 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR			
Male	White	Jan. 24, 1898	70 YRS					Sept. 24,			3:00 PM			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH								
Maryland		U.S.A.				Baltimore								
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Bowleys Quarters			294 Cold Spring Rd.			Policeman-ret.								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Md.						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3440 Elmora Ave.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William			Schweikart			Laura Tiemann								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
						Elmer J. Schweikart, 294 Cold Spring Rd. 21220								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY?								
			None			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			M.B. Davis			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED					
EXAMINER'S NAME (Type)			M.B. Davis, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			9/26/68					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, P.O. Box, or County) Dundalk, Md.					
23a BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			9/27/68			Baltimore Cemetery			Baltimore, Md.					
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Ullrich Funeral Home Dundalk, Md.						DATE SEP 27 1968			J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
SEDERS,			GORMAN			L.			Month 09 Day 01 Year 68 8:55aM					
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (n years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Cauc		2-14-1898			70 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH							
Maryland		U. S. A.					Baltimore Co.,			Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Towson			GEMC TOWSON, MD. 21204			Marketing Mgr. C&P Telephone Co								
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Balto.			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6012 Huntridge Road		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
John I. Seders			Ella Hemp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			WWI			212-10-0873			C.C. Haley, Jr. (son-in-law)			7709 Rider Hill Rd. Ruxton, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS														
4104 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) ARTERIOSCLEROSIS														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
4201														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
		HOUR A.M. Month Day Year		D.O.A										
		P.M. 9 01 1968												
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State				
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		home		6012 Huntridge Road		Balto, Md.		21210						
22a. I certify that (I) (this hospital) attended the deceased from Aug 20, 1968, to 9/1, 1968, that (I) (we) last saw the deceased alive on 9/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						ATTENDING PHYSICIAN		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED				
Dr. William Yeh M.D.						G.B.M.C. 6701 N. Charles St 21204				9/1/68				
22d. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)				
		Burial		9/4/68		Cedar Hill		Ritchie Hwy. A.A. Co., Md.						
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		SEP 4 1968		Charles Judge										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Lena Seidman				2a. DATE OF DEATH Month Day Year 9 23 68				2b. HOUR 4.20			
3 SEX Female		4. RACE White		5 DATE OF BIRTH 7-7-92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Balto. Co. Gen. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7426 Prince Geo Rd.			
14. FATHER'S NAME First Middle Last Morris Fiebert				15. MOTHER'S MAIDEN NAME First Middle Last IDA ?							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO NO		17 INFORMANT Address MRS. ESTHER GOLDBLOOM, 7426 PRINCE GEORGE RD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory + Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Severe diarrhea 3 weeks DUE TO, OR AS A CONSEQUENCE OF (c) intestinal obstruction due to sigmoid volvulus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 570											
19a DATE OF OPERATION Sept 14 + 15		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED intest obstruct. 14th Sept eviscerated 15th Sept		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from 13 Sept, 1968 , to 23 Sept, 1968 , that (I) (we) last saw the deceased alive on Sept 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Samuel J. Abrams MD		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 9/23/68					
22d. PHYSICIAN'S NAME (Type) Samuel J. Abrams MD		22e. ADDRESS 2220 Park Heights Ave - 21208									
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 9-25-68		23c. NAME OF CEMETERY OR CREMATORY PROGRESSIVE SICK BENEFIT & RELIEF, ROSEDALE, MARYLAND		23d. LOCATION (City or Town) (County) (State) Baltimore					
24 FUNERAL DIRECTOR XXXXX SOL LEVINSON & BROS., 6010 REISTERSTOWN RD		ADDRESS		25a REC'D BY REGISTRAR SEP 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

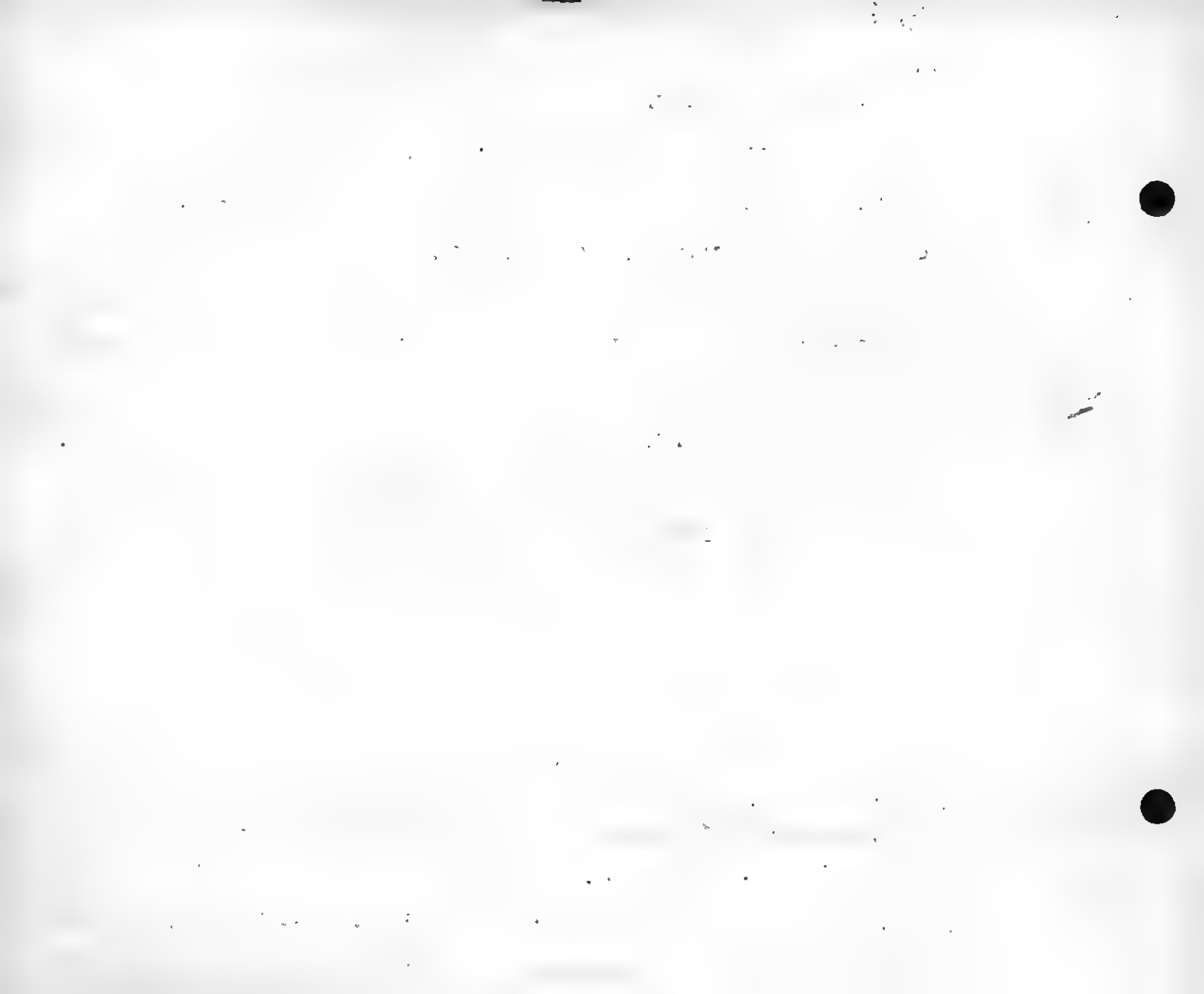


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12696
CERTIFICATE OF DEATH

12706

1 DECEASED-NAME (Type or print) First Middle Last STEPHEN DAVID SEVIER			2a. DATE OF DEATH Month Day Year 09 07 68			2b. HOUR PM 4:10				
3 SEX MALE		4. RACE CAUCASIAN		5 DATE OF BIRTH 09-07-68		6. AGE (In years last birthday) YRS. MONTHS DAYS 4 4 6		IF UNDER 1 YEAR MONTHS DAYS 4 6		
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE COUNTY				
10 CITY OR TOWN OF DEATH TOWSON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CEN.			12a USUAL OCCUPATION (Kind of work done during most of work.ing life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last BENJAMIN BEARD SEVIER			15. MOTHER'S MAIDEN NAME First Middle Last MARJORIE GAMBLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) IMMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 HRS. 4 HRS. 4 HRS.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7725										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 68 , to 9-7 , 19 68 , that (I) (we) last saw the deceased alive on 9-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James R Brown						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 09-07-68		
22d. PHYSICIAN'S NAME (Type) JAMES R. BROWN M.D.				22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER						
23a BURIAL, CREMATION, REMOVAL (Specify) DISPOSAL		23b. DATE 9-07-68		23c. NAME OF CEMETERY OR CREMATORY GREATER BALTIMORE MED. CEN. TOWSON, MARYLAND			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR R. R. R. R.				ADDRESS GBMC		25a. REC'D BY REGISTRAR DATE SEP 13 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12697

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12707

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
BINA			B.		SHEPARD	Month Day Year 09 07 1968			12p M		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Cauc		5-9-1898		70 YRS.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
Canada		U.S.A.				Baltimore Co. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			GBMC Towson, Md.			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM 157		13e. STREET AND NUMBER	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4132 Westview Road	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Adam					Ballentine	Margaret					Galloway
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
			214-22-1336			Hugh B. Shepard, 8412 Macauley Ct., Balto.Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Condit ans, if any, which gave rise to immed ate cause (a), stating the underlying cause last											
(b) <u>Generalized arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Arteriosclesotic heart disease/Myocard-ial infarct/Chronic brain syndrome</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County	State
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>09-03</u> , 19 <u>68</u> , to <u>09-07</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>09-07</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
<u>D. Coralis</u>										<u>9-7-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>D. Coralis</u>										22e. ADDRESS	
										<u>GBMC 6701 N. Charles St. Balto. md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Sept. 11, 1968		Dulaney Valley Mem. Gar.		Cookeysville, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks Towson,		1050 York Road Towson, Maryland 21204		DATE		<u>SEP 10 1968</u>		<u>Charles Judge</u>			



FOR STATE HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12698										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12708									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1 DECEASED NAME (Type or Print) <i>Joseph Leland Sidaway</i>										2a DATE KNOWN OF DEATH <i>9/24/68</i>										2b HOUR <i>5A</i>									
3 SEX <i>Male</i>										4 RACE <i>White</i>										5 DATE OF BIRTH <i>10/26/67</i>									
6 AGE (n years last birthday) <i>10 YRS 29</i>										7a BIRTHPLACE (State or foreign country) <i>Maryland</i>										7b C. T. ZEN OF WHAT COUNTRY? <i>USA</i>									
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH <i>Baltimore</i>										2c DATE PRONOUNCED DEAD <i>9/24/68</i>									
10 CITY OR TOWN OF DEATH <i>Haltherpe</i>										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2029 Monumental Ave.</i>										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Child</i>									
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <i>Maryland</i>										13b COUNTY <i>Baltimore</i>										13c CITY OR TOWN <i>Haltherpe</i>									
14 FATHER'S NAME <i>Robert Sidaway</i>										15 MOTHER'S MAIDEN NAME <i>Patrica Miller</i>										13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>										16b SOCIAL SECURITY NO. <i>None</i>										17 INFORMANT ADDRESS <i>Robert Sidaway Same as # 13</i>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>7589</i>										DUE TO, OR AS A CONSEQUENCE OF <i>Congenital Heart Defect</i>										<i>11 months</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF									
(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a DATE OF OPERATION <i>12/4/67</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO									
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>										2b TIME OF INJURY Month Day, Year <i>PM 19</i>										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F. No City or Town County State									
22a. I certify that I took charge of the remains described above, he died an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <i>J. Nelson McKay</i>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b DATE SIGNED <i>9/24/68</i>									
EXAMINER'S NAME (Type) <i>J. Nelson McKay 6014 Edmondson Ave. Baltimore Maryland</i>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>										23b DATE <i>9/25/68</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>									
24 FUNERAL DIRECTOR <i>John T. Stansbury 6411 Windsor Mill Rd.</i>										23d LOCATION (City or Town) (County) (State) <i>Woodlawn Balto. Maryland</i>										25a REC'D BY REGISTRAR <i>SEP 25 1968</i>									
										25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>																			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 405
10-7-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12699

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

1 DECEASED-NAME (Type or Print) ROBERT			First EDWARD			Middle SIES			Last			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Sept. Day 16 , Year 1968			2b. HOUR 2:15 P.M.								
3 SEX Male			4 RACE White			5 DATE OF BIRTH March 7, 1928			6 AGE (In years last birthday) 40 YRS			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS HOURS MIN. 			2c. DATE PRONOUNCED DEAD Month Sept. Day 16 , Year 1968			2d. HOUR 2:15 P.M.		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore														
10 CITY OR TOWN OF DEATH Westminster			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Parkton Beckleyville Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Stone														
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Rt 3											
14. FATHER'S NAME First Edward Middle Sies Last 			15. MOTHER'S MAIDEN NAME First Mary Middle Warner Last 																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. WW 2 212-24-7261			17. INFORMANT Clara Sies			ADDRESS Rt 3 Westminster, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>891.8 Acute ethylism</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year Unk HO. R.A.M. Sept.?? 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Asphyxiated in car																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) Car			21f. LOCATION Street or R.F.D. no Beckleyville Rd. City or Town Balto. County Md. State 																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Ronald N. Kornblum			EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED September 17, 1968														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 19, 1968			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore City, Md.														
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.			ADDRESS 			25a. REC'D BY REGISTRAR SEP 20 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 410
300A REV 1-68

12700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12710

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First John	Middle Henry	Last Smidt	2a DATE OF DEATH Month Day Year Sept. 10, 1968			2b HOUR 9:40 p.m.		
3 SEX male		4 RACE white		5 DATE OF BIRTH June 24, 1887		6 AGE (in years) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Czecho.		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) butcher		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY BALTO.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIM 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 339 South Furrow St.			
14 FATHER'S NAME First Middle Last ? H U D A C A K			15 MOTHER'S MAIDEN NAME First Middle Last C A T H E R I N E G R A S S E R								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service) No NONE		16b SOCIAL SECURITY NO 216-03-0978A		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with metastases DUE TO, OR AS A CONSEQUENCE OF to the bones Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177x											
19a DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that the this hospital) attended the deceased from July 29, 1968, to Sept. 10, 1968, that (I) we lost saw the deceased alive on Sept. 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death											
22b SIGNATURE <i>Anthony J. Young</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 9-11-68				
22d PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.					22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 9-14-68		23c NAME OF CEMETERY OR CREMATORY WESTERN		23d. LOCATION (City or Town) BALTIMORE, -		(County)		(State) Md	
24 FUNERAL DIRECTOR Geo. L. Schwab Funeral Home Francis W. Miller 2101 Frederick Ave.					25a. REC'D BY REGISTRAR DATE SEP 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Baby Boy					Smith	Month 9 Day 18 Year 1968		M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		9/18/68		YRS.		3	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Baltimore,			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital			N/A.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland						Baltimore		3135 Hudley Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Donald					Smith	Carol		Ann	Jennings
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Prematurity</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(e)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that it (this hospital) attended the deceased from <u>9/18/</u> , 19 <u>68</u> , to <u>9/18/</u> , 19 <u>68</u> , that it (we) last saw the deceased alive on <u>9/18/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
<i>Harry T. Wilson</i>		9/19/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Harry T. Wilson, M.D.		1611 York Rd., Baltimore, Md. 21212							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
9-23-68		9-23-68		W. Ind. Med. School		Baltimore Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				DATE SEP 26 1968		<i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1544
30M REV 1/68

12702

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12712

1. DECEASED-NAME (Type or print) Dorothy Elizabeth Smith			2a. DATE OF DEATH Month 9 Day 30 Year 1968			2b. HOUR 3:40PM					
3 SEX Female		4 RACE White		5. DATE OF BIRTH October 2, 1899		6. AGE (In years last birthday) 68 69 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 115 E. Susquehanna Ave.		
14. FATHER'S NAME First Middle Last Edward Ruth			15. MOTHER'S MAIDEN NAME First Middle Last Anna Gibson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-18-0406A		17. INFORMANT Mr Edward J Smith			Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable incomplete basilar artery thrombosis 4/41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/18/ , 19 68 , to 9/30/ , 19 68 , that 4 (we) last saw the deceased alive on 9/30/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Camilo Tomboc						DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-30-68	
22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/3/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland						25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 1-68

12702

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12713

1 DECEASED-NAME (Type or print) John Prmiz Smith			2a DATE OF DEATH Month 9 Day 27 Year 68		2b HOUR 6:15 P.M.
3 SEX Male	4 RACE white	5 DATE OF BIRTH 12-28-1910		6 AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) 1	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto Co.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 519 Hampton Lane		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) M.D.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto	13c CITY OR TOWN Towson	13e STREET AND NUMBER 579 Hampton Lane	
14. FATHER'S NAME -- First Middle Last William Smith			15. MOTHER'S MAIDEN NAME First Middle Last Ida Pring		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) Yes		16b SOCIAL SECURITY NO 212 34 7651		17 INFORMANT Kathaleen Smith, Towson, Md. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if only, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yr.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 None					
19a. DATE OF OPERATION No		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9/24 , 19 68 , to 9/27 , 19 68 , that (I) (we) last saw the deceased alive on 9/24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE David A. Oursler M.D.				22c. DATE SIGNED 9/28/68	
22d. PHYSICIAN'S NAME (Type) David A. OURSLER, M.D.				22e. ADDRESS 1118 St. Paul St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 30, 68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204				25a. REC'D BY REGISTRAR SEP 30 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

12704

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12711

1. DECEASED-NAME (Type or print) William Leonard Smith			2a. DATE OF DEATH 9 Month 28 Day 68 Year			2b. HOUR 11:15 PM			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH 1-10-1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Balto. Med. Cent.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Executive		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 334 Broadmoor Rd.	
14. FATHER'S NAME First Middle Last William H. Smith			15. MOTHER'S MAIDEN NAME First Middle Last Anna R. Warner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 212-01-1603		17. INFORMANT Helen R. Smith		Address Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 441.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451.0									
19a. DATE OF OPERATION 9/28/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-28 , 19 68 , to 9-28 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-28 , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE S. F. Naeim				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-29-68			
22d. PHYSICIAN'S NAME (Type) Faramarz Naeim				22e. ADDRESS GBMC 6701 N. Charles St. Balto. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE 10-2-68		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto.		25a. REC'D BY REGISTRAR OCT 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Jennie			NMI	Snyder		Month	Day	Year	8:05
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White				78		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
LITHUANIA		U.S.A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Balto. County Gen. Hosp				TAILORING STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			✓		Balto.		YES		4000 Fallstaff Rd.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
unknown						unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO			218-03-4109		MRS. BESSIE GLASSMAN				4000 FALLSTAFF RD. #15
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>1950</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (th/s hospital) attended the deceased from <u>Aug 24</u> , 19 <u>68</u> , to <u>Sept 2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Wenifredo N. Iglesia			M.D.					9/2/68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
WENIFREDO N. IGLESIA			BALTIMORE COUNTY GENERAL HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		9-3-68		WORKMEN CIRCLE		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						DATE SEP 5 1968		Charles Judge	

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1

12706

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12716

1 DECEASED-NAME (Type or print) LORA			First Middle Last NMN SPEDALERE			2a DATE OF DEATH 09th 01st 68th			2b HOUR 12:50 PM		
3 SEX FEMALE			4 RACE CAUCASIAN			5 DATE OF BIRTH 04-23-22			6 AGE (In years last birthday) 46 YRS		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE COUNTY Md.		
10 CITY OR TOWN OF DEATH TOWSON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CEN.			12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY N/A		
13a USJAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND			13b COUNTY BALTIMORE			13c CITY OR TOWN LUTHERVILLE			13d INSIDE CITY LIM TSP NO		
13e STREET AND NUMBER 242 MARGATE ROAD			14 FATHER'S NAME First Middle Last JOHN ROCCHI			15 MOTHER'S MAIDEN NAME First Middle Last ROSE GIANNARINI					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b SOCIAL SECURITY NO #001219 18 4919			17 INFORMANT Hospital Records			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GRAM NEGATIVE SEPTICEMIA AND ACUTE PURULENT MENINGITIS DUE TO, OR AS A CONSEQUENCE OF (b) DIVERTICULITIS WITH PERFORATION AND INTRAABDOMINAL ABSCESSSES DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-15 , 19 68 , to 9-1 , 19 68 , that (I) (we) last saw the deceased alive on 9-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9-1-68		
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN M.D.						22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 5, 68			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION (City or Town) (County) (State) Cockeysville, Balto. Md.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.						25a. REC'D BY REGISTRAR SEP 4 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



12707

CERTIFICATE OF DEATH

12717

1 DECEASED NAME (Type or print) <i>Clarence Edward Steer</i>			2a. DATE OF DEATH Month <i>Sept</i> Day <i>4</i> Year <i>1968</i>			2b. HOUR <i>6:45 A.M.</i>	
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>Sept 22, 1890</i>		6 AGE (In years last birthday) <i>77</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>	
10. CITY OR TOWN OF DEATH <i>Cockeysville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Md. Masonic Home</i>		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) <i></i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Nevada</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Las Vegas</i>		13d. INSIDE CITY LIM TST YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>616 Princetown Street</i>		14. FATHER'S NAME First <i>Andrew</i> Middle <i>W</i> Last <i>Steer</i>		15. MOTHER'S MAIDEN NAME First <i>Sydia</i> Middle <i>-</i> Last <i>Meads</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>2160 3-6593</i>		17. INFORMATION Address <i>Records Md. Masonic Home</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary artery occlusion.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aortic arch occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 15, 1965</i> , to <i>August 30, 1968</i> , that (I) (we) last saw the deceased alive on <i>August 30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jamshid Hamad MD</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>9/3/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>JAMSHID HAMED MD</i>		22e. ADDRESS <i>Md. Masonic Home, Cockeysville</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>9-7-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LOUDON PARK</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTO - Md.</i>	
24. FUNERAL DIRECTOR <i>Wm Cook - Brooks, Towson</i>		ADDRESS <i>1050 YORK RD.</i>		25a. REC'D BY REGISTRAR <i>SEP 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CHARLOTTE DODSON STEIN						2a. DATE OF DEATH Month 09 Day 01 Year 68			2b. HOUR 12:50 PM		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 02-14-21		6. AGE (In years lost birthday) 47 YRS.		7. UNDER 1 YEAR MONTHS 00 DAYS 00		7. UNDER 24 HRS. HOURS 00 MIN. 00	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md					
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) GREATER BALTO. MED. CEN.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN TIMONIUM		13d. INSIDE CITY (Y.M.T.S?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11 BELFAST ROAD		
14. FATHER'S NAME First Middle Last CHARLES R OLIVER				15. MOTHER'S MAIDEN NAME First Middle Last VIOLET E HUTCHINSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF LUNG WITH WIDE-SPREAD METASTASES DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 162											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-29 , 19 68 , to 9-1 , 19 68 , that (I) (we) last saw the deceased alive on 9-1 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9-1-68			
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN, M.D.						22e. ADDRESS GREATER BALTIMORE MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md. Balto. Co.		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
24. FUNERAL DIRECTOR Win. Cook-Brooks Towson, Towson, Md.						25a. REC'D BY REGISTRAR DATE SEP 4 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12719

1. DECEASED NAME (Type or print) <i>Valborg C. Steinbock</i>			2a. DATE OF DEATH Month <i>Sept</i> Day <i>17</i> Year <i>1979</i>		2b. HOUR <i>7:45</i> M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Sept 17, 1879</i>		6. AGE (In years last birthday) <i>89</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Sweden</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore Co.</i>		
10. CITY OR TOWN OF DEATH <i>Columbia, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Severna Park Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Albany County</i>	13c. CITY OR TOWN <i>Palestine</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>G. Steinbock</i> Middle Last	15. MOTHER'S MAIDEN NAME First <i>Sophia</i> Middle Last <i>Unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <i>No</i>		
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Borealis pneumonia</i> <i>2507</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i> Approximate interval between onset and death <i>3 days</i> <i>years</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>9-22</i> , 19 <i>68</i> , to <i>9-22</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Manuel J. Rodriguez</i>		22c. DATE SIGNED <i>9-22-68</i>		22d. PHYSICIAN'S NAME (Type) <i>Manuel J. Rodriguez</i>	
22e. ADDRESS		23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>			
23b. DATE <i>9-25-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>McCully</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

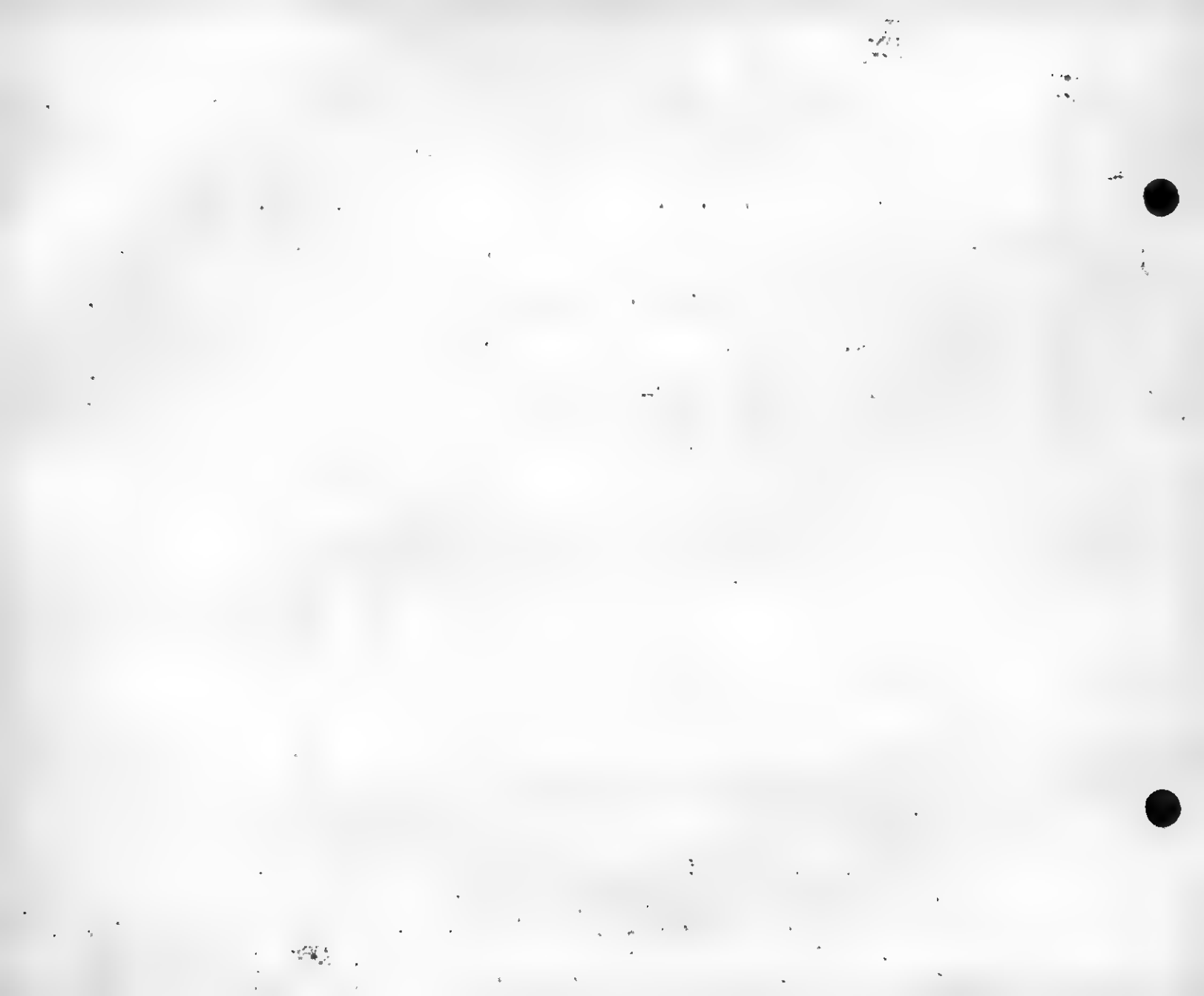
12710

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12720

1. DECEASED-NAME (Type or print) First Middle Last Lewis Kimble Stewart			2a. DATE OF DEATH Month 9 Day 23 Year 68		2b. HOUR 3:30 PM
3. SEX male	4. RACE white	5. DATE OF BIRTH 11-6-1900		6. AGE (In years lost birthday) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Balto. County Md.		
10. CITY OR TOWN OF DEATH Pikesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 22 Maryland Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) engineer	12b. KIND OF BUSINESS OR INDUSTRY Dendix		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Balto.	13c. CITY OR TOWN Pikesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 22 Maryland Ave.	
14. FATHER'S NAME First Middle Last George A. Stewart	15. MOTHER'S MAIDEN NAME First Middle Last Jennie (unknown) Furrion				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO 150-07-9850	17. INFORMANT (wife) 22 Maryland Ave. Bertha Marie Stewart 21208			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>5271</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hiatal Hernia</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 1964, to <u>Sept 23</u> , 1968, that (I) (we) last saw the deceased alive on <u>9-21</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <u>Charles H. Williams</u>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 9-23-68	
22d. PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>	22e. ADDRESS <u>Pikesville, 21208, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept. 25, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Plowden C. Cemetery</u>	23d. LOCATION (City or Town County State) <u>Plowden C. Cemetery Balto Md.</u>		
24. FUNERAL DIRECTOR <u>Frank D. Howell</u>	ADDRESS <u>Pikesville, Md</u>	25. RECEIVED BY REGISTRAR <u>SEP 26 1968</u>	25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 4 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR				
Mrs. Leona Marie Stigile						Sept. 7 1968			3:40 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (n years lost birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		
female		white		July 14, 1888			80 YRS.		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10. Mo	
Switzerland (Lucerne)			U.S.A.						Balto.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Cockeysville			Bonnie Blink			Housewife			Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Md. 21212			Batter			Balto.			YES			606 41st St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Ernest Russell			Mina Wyniger										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
			213-18-7459			Records of Mr. Mason			Home			Cockeysville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
DUE TO, OR AS A CONSEQUENCE OF													
1. Central pneumonia													
DUE TO, OR AS A CONSEQUENCE OF													
2. White Bronchopneumonia													
DUE TO, OR AS A CONSEQUENCE OF													
3. Gram-negative bacillary pneumonia													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
231X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from August 15, 1965, to Sept. 7, 1968, that (I) (we) last saw the deceased alive on Sept. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
James H. Apple			9/7/68			James H. Apple			1050 N. 1st St. Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			9/10/68			London Park			Baltimore Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Wm. Carl Brooks-Townson			SEP 10 1968			Charles Judge							



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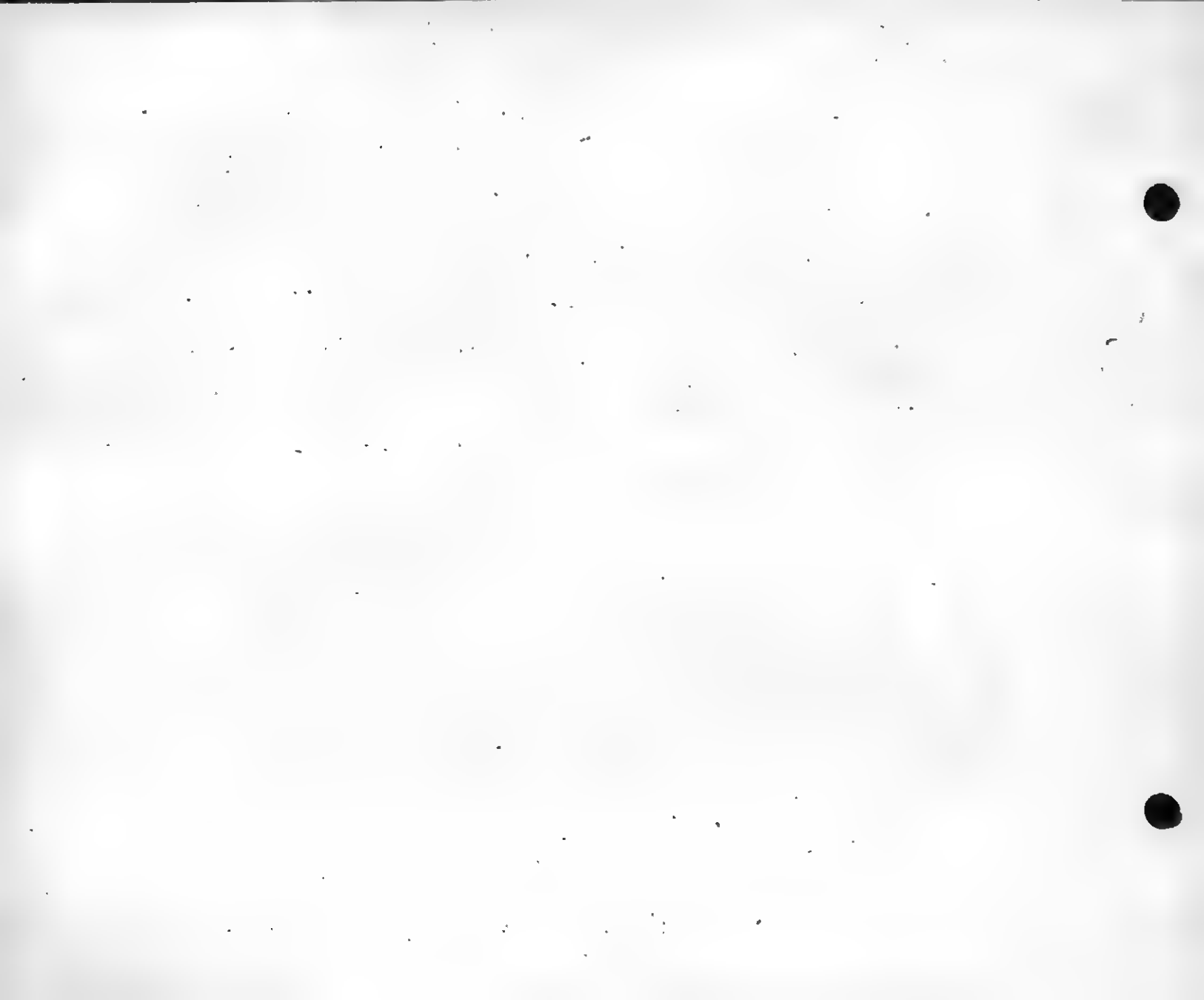
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12712

12/25/68

1. DECEASED NAME (Type or print) Isabel W. Stiles			2a. DATE OF DEATH 9 Month 26 Day 68			2b. HOUR 11:25 A.M.			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH 4/27/86		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Garrison, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jessie H. Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admissible) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5638 GOVANE AVE	
14. FATHER'S NAME First Middle Last Edward Whiting			15. MOTHER'S MAIDEN NAME First Middle Last Mary Verguson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			
16b. SOCIAL SECURITY NO. 071-09-7806A-B			17. INFORMANT J. Newton Stiles			Address 5638 Govane Ave. Balto.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4861 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4928 (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-7 , 19 67 , to 9-26 , 19 68 , that (I) (we) last saw the deceased alive on 9-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE David J. Miller		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-26-68			
22d. PHYSICIAN'S NAME (Type) David J. Miller		22e. ADDRESS 9115 Reisterstown Rd. Camp Hill, Pa.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) ELMIRA N.Y.			
24. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.		25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M R11

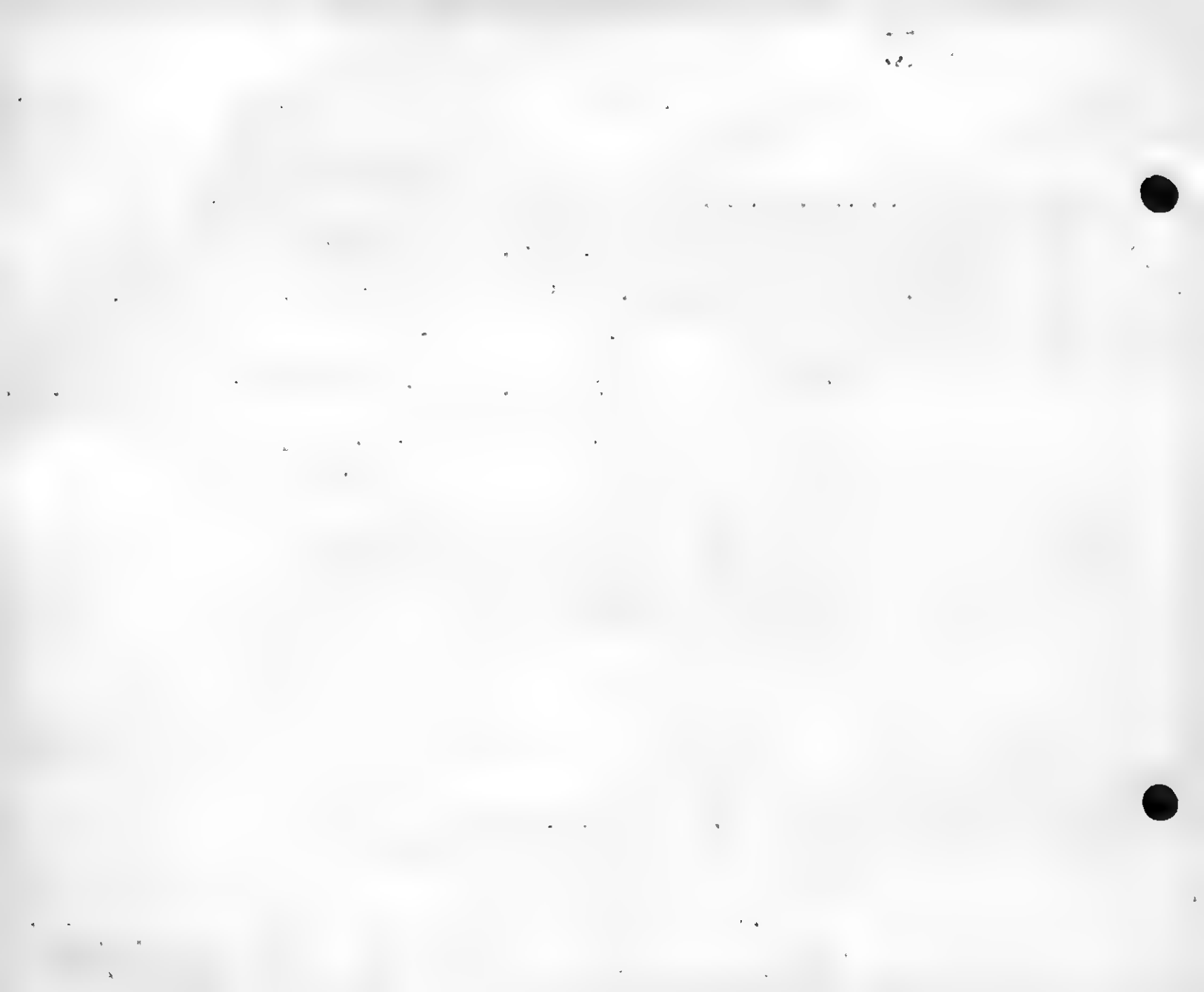
12713

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12723

1. DECEASED-NAME (Type or print) First Middle Last Helen Marie Stinchcomb			2a. DATE OF DEATH Month Day Year Sept. 26 1968			2b. HOUR MIN 4:40 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Sept. 19, 1903		6 AGE (In years last birthday) 65 YRS		F. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Baltio. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Pikesville		11 NAME OF HOSPITAL OR INSTITUTION (If at home, give street address) 7214 Rockridge Rd.		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) Md.		13b COUNTY Baltio.		13c CITY OR TOWN Pikesville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7214 Rockridge Rd.	
14 FATHER'S NAME First Middle Last Joseph Stewart			15. MOTHER'S M.A.DEN NAME First Middle Last Ida Mae Hoffman						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) None		16b. SOCIAL SECURITY NO 216-32-7252		17. INFORMANT Address Mr. Maurice Stinchcomb, 7214 Rockridge Rd., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>malignant pneumonia</i></u> DUE TO, OR AS A CONSEQUENCE OF <u><i>c. wide dissemination</i></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u><i>19.</i></u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u><i>19</i></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u><i>9/26</i></u> , 19 <u><i>68</i></u> , to <u><i>9/26</i></u> , 19 <u><i>68</i></u> , that (I) (we) last saw the deceased alive on <u><i>9/26</i></u> , 19 <u><i>68</i></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Leonard M. Listel</i>		22c. DATE SIGNED <u><i>9/27/68</i></u>		22d. PHYSICIAN'S NAME (Type) LEONARD M. LISTEL, M.D.		22e. ADDRESS 711 PARK HEIGHTS AVE			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Sept. 30, 1968		23c NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d LOCATION (City or Town) (County) (State) Randallstown Carroll, Md.			
24. FUNERAL DIRECTOR <i>Frank H. Newell</i>		25a REC'D BY REGISTRAR DATE OCT 2 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1958

12714

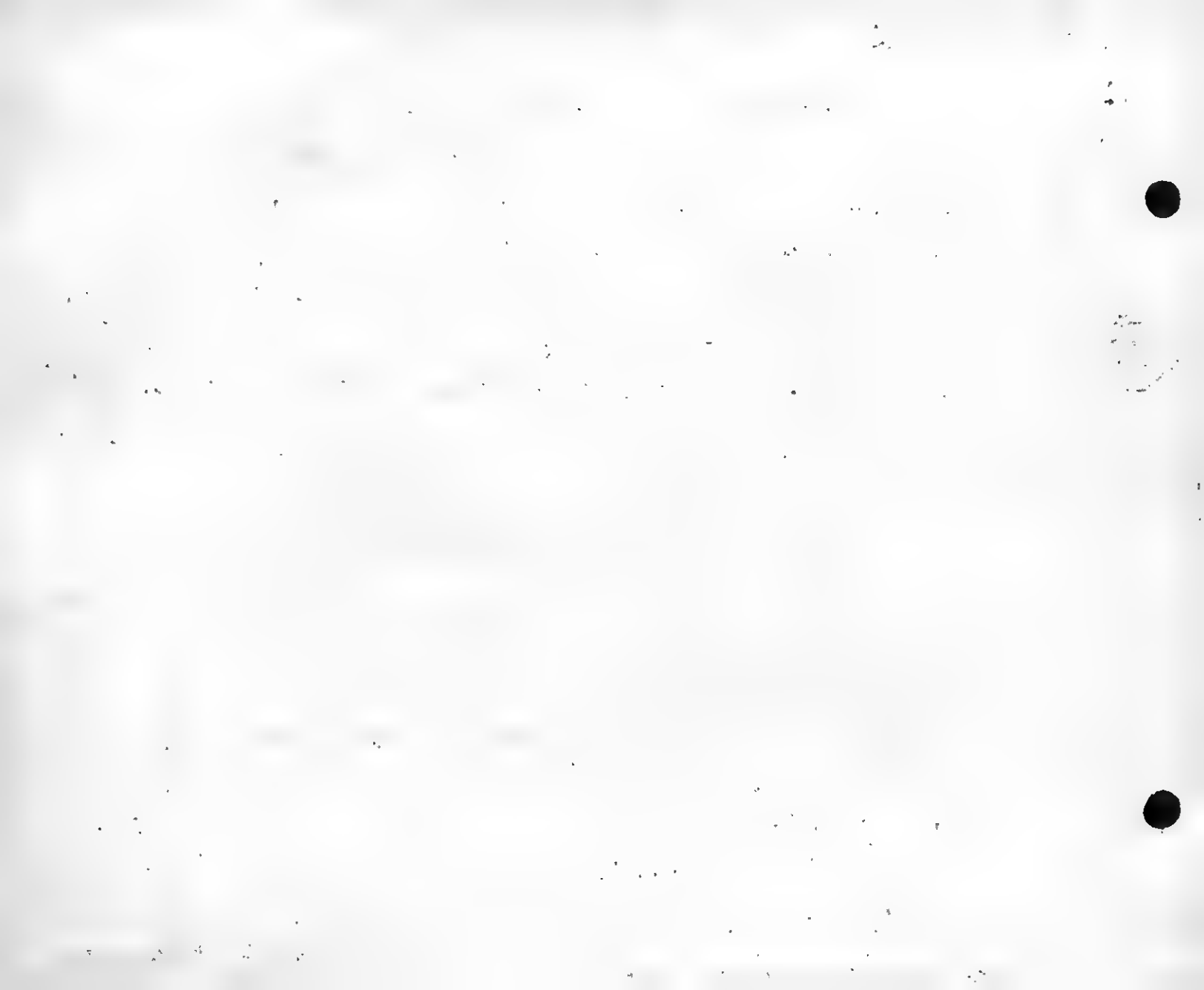
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12721

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Katherine</i> <i>Stoerlein</i>			2a. DATE OF DEATH 9 Month 12 Day 68 Year			2b. HOUR 4:35 P.M.	
3. SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>April 17, 1888</i>		6 AGE (In years last birthday) 80 YRS	
7a BIRTHPLACE (State or foreign country) <i>Germany</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md	
10 CITY OR TOWN OF DEATH <i>Catonsville</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Summit Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Presser</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Balto.</i>		13c CITY OR TOWN <i>Balto.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>309 So. Smallwood St.</i>		14 FATHER'S NAME First Middle Last <i>Fuehsurger</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Weigan</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>212-10-4783A</i>		17 INFORMANT <i>Loretta Stoerlein - 309 So. Smallwood St.</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONITIS</i> <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>492X</i> <i>A.C.U.I.D.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1</i> , 19 <i>62</i> , to <i>9-12</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9-10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>John F. Schaefer MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>9-15-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN F. SCHAEFER</i>		22e ADDRESS <i>401 RANDOM RD. 21229</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-16-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>		23d LOCATION (City or Town) (County) (State) <i>Balto., Md.</i>	
24 FUNERAL DIRECTOR <i>Walters Funeral Hme. Pratt & Stricker Sts</i>		ADDRESS		25a REC'D BY REGISTRAR <i>SEP 16 1968</i>		25b REGISTRAR'S SIGNATURE <i>John Charles Judge</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

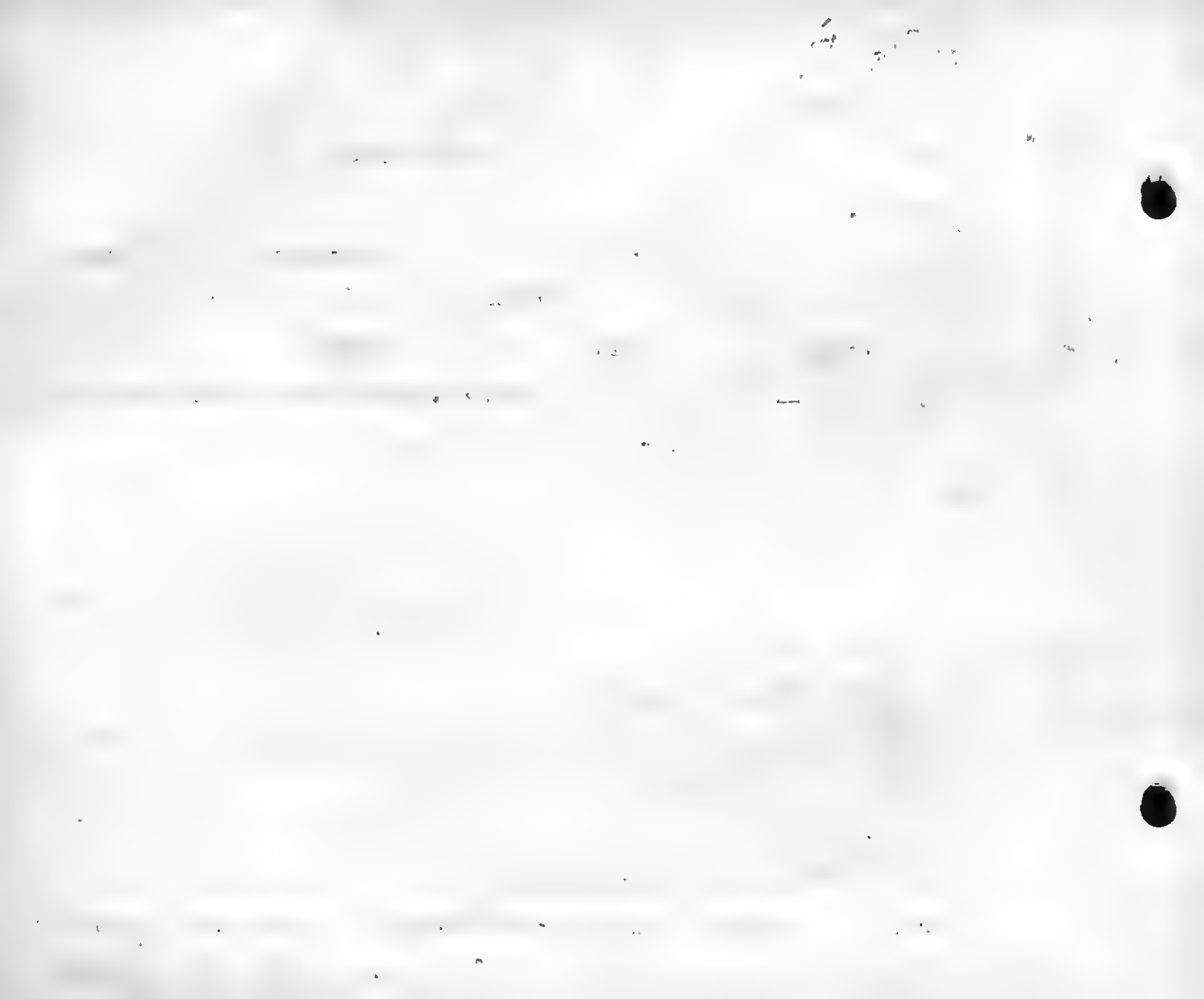
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12725

1. DECEASED NAME (Type or print)		First	Middle	Last	2c. DATE OF DEATH Month Day Year		2b. HOUR	
Frank		L.	Swiss	September 28, 1968		3:15 PM		
3 SEX	4 RACE		5 DATE OF BIRTH		6. AGE (In years birthday)	7. UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male	White		April 9 1906		62 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md
Maryland.		U S A		Baltimore				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson 4		St. Joseph Hospital		Pharmacist		Drugs		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1100 Stevenson Lane #4
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Joseph				Swiss	Rose			PIECHOCKI
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address
No				218-32-2403		Sophia M. Swiss		1100 Stevenson Lane 21204
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>42.1</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 26</u> , 19 <u>68</u> , to <u>Sept. 28</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Sept. 28</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(not)</u> view the body after death.								
22b. SIGNATURE <u>Beatriz Dizon M.D.</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED Sept. 28, 1968	
22d. PHYSICIAN'S NAME (Type) Beatriz Dizon, M.D.					22e. ADDRESS 7620 York Road, Towson 4, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Oct 1 1968		Dulaney Valley Memorial		Cockeysville Balto Md		
24 FUNERAL DIRECTOR, ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
THE DIPPEL BROS INC 7110 BELAIR RD.					DATE OCT 2 1968		J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

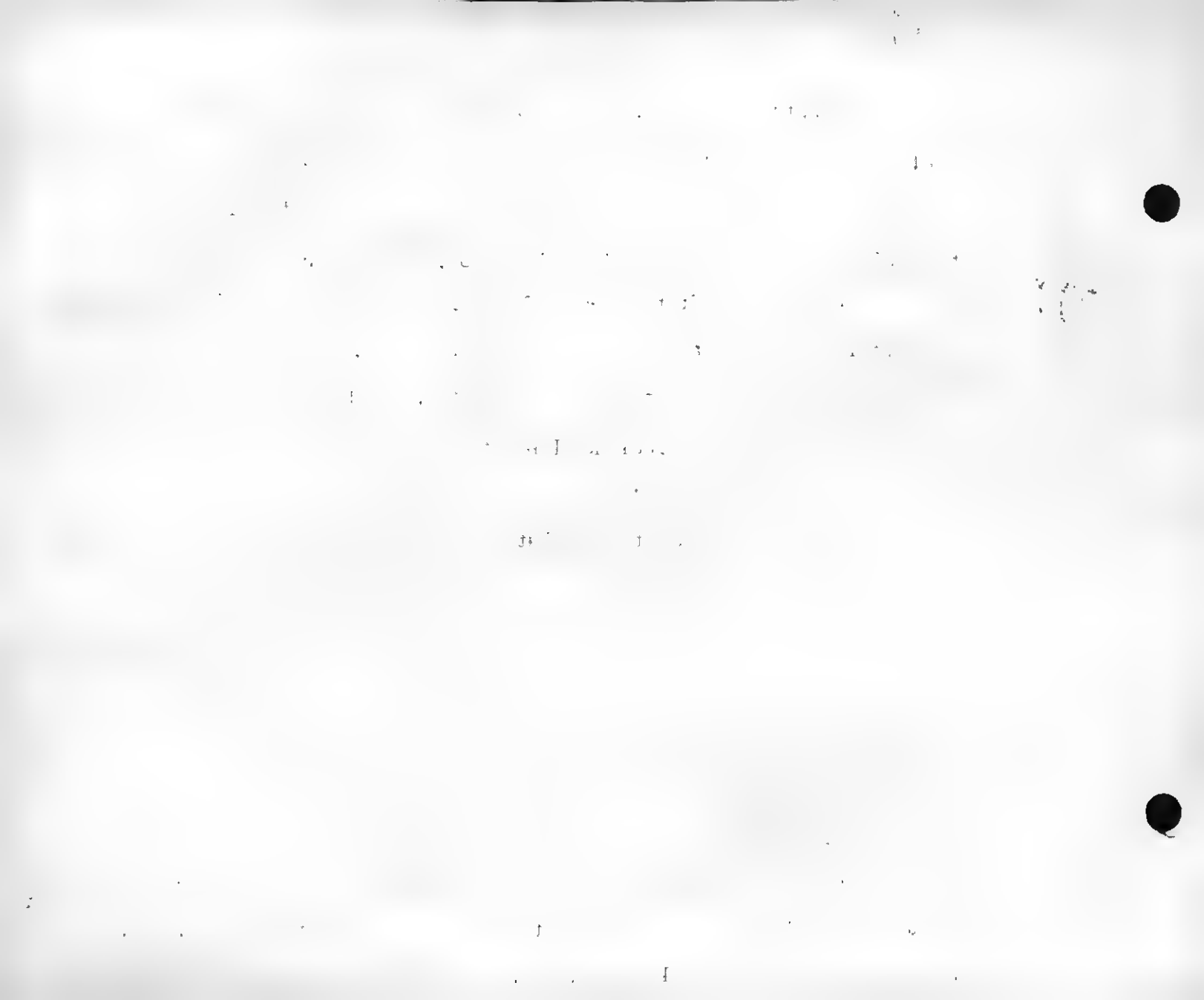
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12716

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Chester B. Taylor			2a DATE OF DEATH Month 9 Day 17 Year 1968		2b HOUR 6 a M
3 SEX Male	4 RACE Cau	5 DATE OF BIRTH 4/26/93	6 AGE (In years last birthday) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Conn	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md.		
10 CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines Con.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cab Driver	12b. KIND OF BUSINESS OR INDUSTRY		
13a USUA. RES DENCE (Where deceased lived, if institut an- Residence before admission) STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 305 Lord Byron Lane	
14. FATHER'S NAME First Chester Middle Taylor Last Taylor	15 MOTHER'S MAIDEN NAME First Carrie Middle E. Last Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 111-10-2521		17 INFORMANT Robert T. Taylor Same as 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs 15 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9/2 , 19 68 , to 9/17 , 19 68 , that (I) (we) last saw the deceased alive on 9/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Wilmer K. Gallager MD		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 9/17/68	
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallager MD		22e. ADDRESS 6209 Frederick Ave Balt. Md. 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/19/68	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.		
24. FUNERAL DIRECTOR 1050 York Rd		ADDRESS Wm. Cook-Brooks Towson Inc Balt. Md. 21204	25a. REC'D BY REGISTRAR SEP 19 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-568-22a Fill in 405 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12727

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
EMMA J. THOMAS						Month Day Year			2d. HOUR		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR			
Female	Colored	12-19-1908	59 YRS	MONTHS DAYS HOURS MIN.	Month Day Year			2d. HOUR			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
T.B., Md.		U.S.A.				Balto.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Turner Station			Honeysuckle La. & Cherry La.			Domestic Work					
13a USUA. RESIDENCE (Where deceased lived, if not institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY EMPLOYED?		
Md.						Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Henderson			Hawkins			Georgiana			Hawkins		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mr. John Thomas			103 East Cherry La.			PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF <u>910.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			? HOUR A.M. P.M. 9 ? 19 68			Presumably drowned					
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21b. PLACE OF INJURY (At home, farm street, factory office building, etc.)			21c. LOCATION Street or R.F.D. No. City or Town County State					
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Water			Found: Water at end of Honeysuckle and Cherry Lane					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED					
ACTUAL SIGNATURE			EDWARD F. WILSON, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			EDWARD F. WILSON, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			9/18/69		
23a. BURIAL, CREMATION, REMOVAL, (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			9-21-68			Mount Auburn Cem.			Baltimore, Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
MORTON S. DYETT F.H.			1701 Laurens Street			SEP 20 1968			J. S. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12718

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12728

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Bertha Louise Thompson</i>			2a. DATE OF DEATH Month <i>Sept.</i> Day <i>24</i> Year <i>68</i>			2b. HOUR <i>12 45 A</i> M	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>1-23-91</i>		6. AGE (In years last birthday) <i>77</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i>	
10. CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>BALTIMORE CO. GEN. HOSP.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>RANDALLSTOWN</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Box 235A</i>		13f. STREET AND NUMBER <i>Windy Hill Rd.</i>					
14. FATHER'S NAME First Middle Last <i>Charles Quick</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Catherine Diggs</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, and (If yes give dates of service) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>220-44-4066</i>		17. INFORMANT Address <i>Josephine Chisholm Windy Hill Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>DOA - BALTIMORE CO. GEN. HOSP.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>44127 Antero - Sclerotic Heart Disease.</i>							<i>5 yrs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							(b) <i>Chronic Infectious Arthritis</i>
DUE TO, OR AS A CONSEQUENCE OF							(c) <i>2 yrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized Antero - Sclerotic.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 21</i> , 19 <i>68</i> , to <i>Sept. 24</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>Sept. 21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Earl L. Chambers M.D.</i>				22c. DATE SIGNED <i>9/24/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers - M.D.</i>				22e. ADDRESS <i>4408 Liberty Hts. Balto. Md.</i>			
23a. BURIAL CREMATION, <i>BURIAL</i>		23b. DATE <i>Sept. 26, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn, Balto City, Md.</i>	
24. FUNERAL DIRECTOR <i>Loring Byers</i>				25a. REC'D BY REGISTRAR <i>SEP 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>f Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 4-73. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

12719

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12729

1. DECEASED-NAME (Type or Print) C H A R L E S W I L L I A M T I L L M A N			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Sept. 25 1968			2b. HOUR 7P		
3 SEX Male	4 RACE White	5. DATE OF BIRTH Mar. 29, 1908	6 AGE (In years last birthday) 60 YRS	7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Sept. 25 1968 Month Day Year		
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE		
10 CITY OR TOWN OF DEATH WHITE HALL		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hosp to give street address) WHITE HALL ROAD		2a. US. OCCUPATION (Kind of work done during past 24 hours, including if retired)		2b. KIND OF BUSINESS OR INDUSTRY ROAD CONTRACTOR-RET. SELF EMP.		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c CITY OR TOWN MONKTON		13d INSIDE CITY, TOWN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER JARRETTSVILLE PIKE
14 FATHER'S NAME First Middle Last JOHN TILLMAN			15. MOTHER'S MAIDEN NAME First Middle Last BARBARA SNYDER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes and/or unknown) NO		16b SOCIAL SECURITY NO NONE		17 INFORMANT FAMILY RECORDS		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary Occlusion								
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) trauma								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE A. M. France		EXAMINER'S NAME (Type) A. M. FRANCE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 9/25/68
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE SEPT. 28, 1968		23c NAME OF CEMETERY OR CREMATORY ST. JAMES CEMETERY		23d LOCATION (City or Town) (County) (State) MONKTON, BALTO. CO., MD.		
24 FUNERAL DIRECTOR John Burke's Sons, Towson, Md.				ADDRESS		25a REC'D BY REGISTRAR SEP 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12720

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12720

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
BETTY JANE TITTSWORTH						Month Day Year Sept 13 1968			4:35 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	1-17-1924	44 YRS					Month Day Year Sept 13 1968			5:15 P.M.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U S A						Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown			Balto. Co. Gen. Hospital			At Home					
13a. USUAL RESIDENCE (Where deceased lived, if not in institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md			Baltimore			Woodstock			Granite Motor Court		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Daniel Graham			Mable Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			219 20 0396			Calvin Tittsworth, Woodstock, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic changes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											<u>None</u>
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			SEP 16, 1968		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			9-17-1968			Good Shepherd			Ellicott City, Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John P. Slack			Highbotham-Slack Funeral Home, Ellicott City, Md			SEP 18 1968			Charles Judge		

CERTIFICATE OF DEATH

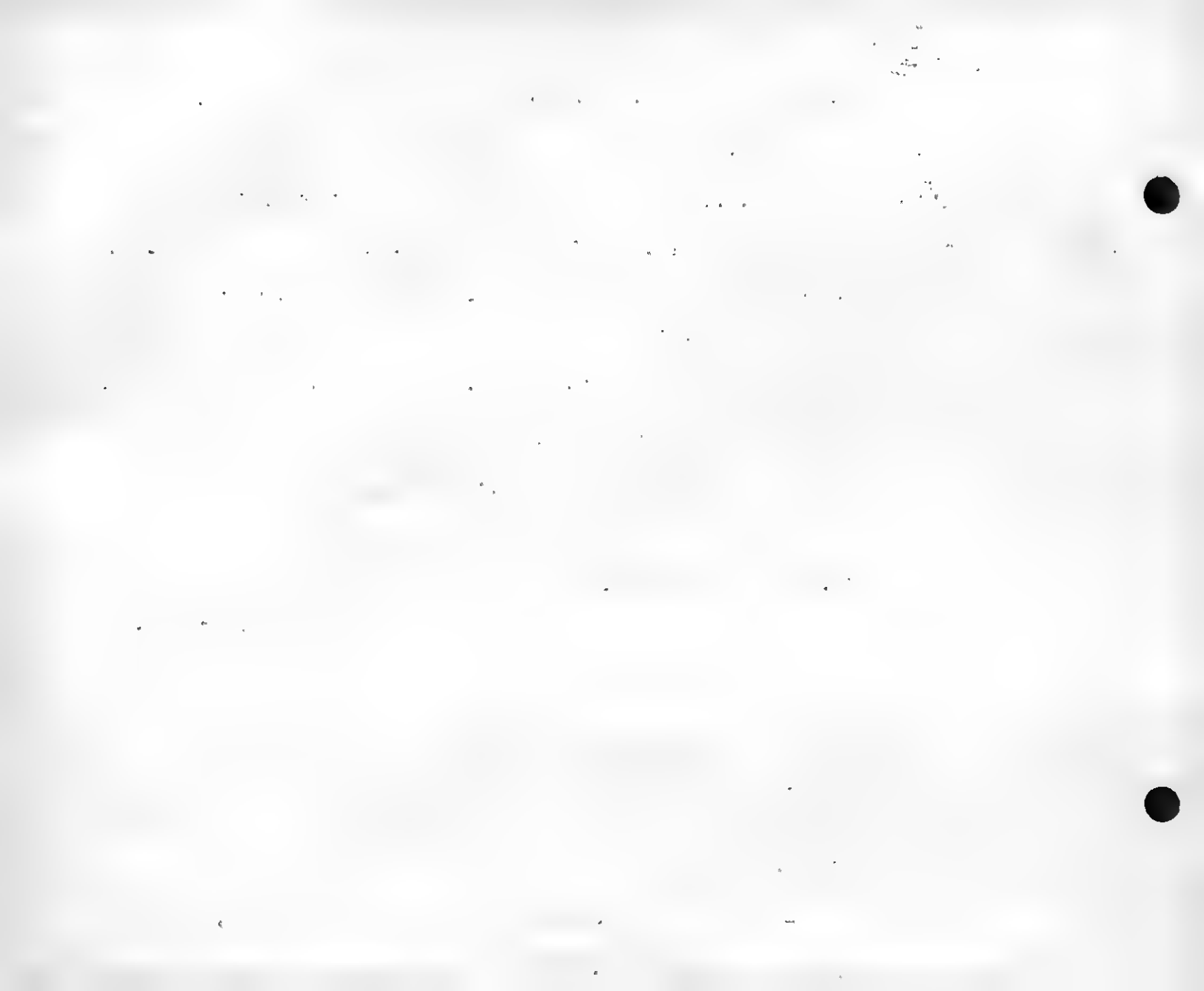
12721

12731

1. DECEASED NAME (Type or print)		First SERAFIN	Middle M.	Last TOMALSKI	2a. DATE OF DEATH Month 9/5/68 Day Year		2b. HOUR 7:50P M	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 5/1/05			6 AGE (In years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE COUNTY, Md				
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VEI. ALM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR IND. STRY CANNERY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13b. COUNTY —	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 16 S. Chester Street			
14 FATHER'S NAME First THOMAS Middle M.D. Last TOMALSKI		15 MOTHER'S MAIDEN NAME First MADYLENE Middle TWARDOWICZ Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give service) YES		16b. SOCIAL SECURITY NO 215 07 00 24		17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no autopsy		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/30/68</u> , 19 <u> </u> , to <u>9/5/68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>9/5/68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>J. D. Talbert, M.D.</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/6/68		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22e. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9-10-68		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR JOHN M WEBER & SONS INC S. CHESTER				25a. RECD BY REGISTRAR 401		25b. REGISTRAR'S SIGNATURE SEP 9 1968 Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

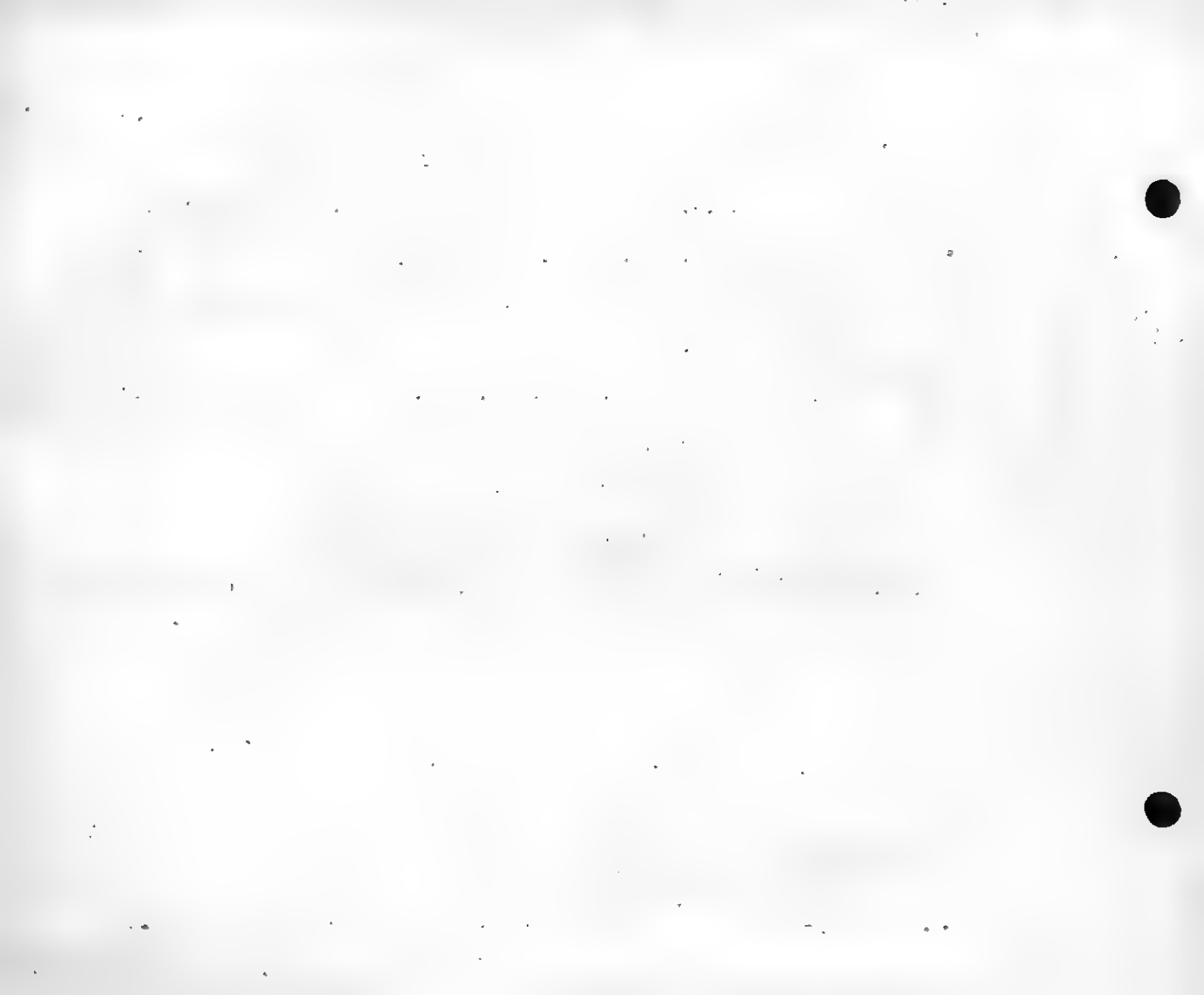
12722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12722

1. DECEASED NAME (Type or print) JAMES LEE TOPPING			2a. DATE OF DEATH Month 9 Day 20 Year 68			2b. HOUR 7:15 AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 1/13/93		6 AGE (In years lost birthday) 75 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY, Md	
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VEET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLUMBER		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last JOHN TOPPING		15 MOTHER'S MAIDEN NAME First Middle Last EBA CROSBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO 218 18 21 71		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEMORRHAGE MASSIVE 21 DUE TO, OR AS A CONSEQUENCE OF (b) PEPTIC ULCERS, STOMACH AND DUODENUM CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 16 (c) BRONCHOGENIC CARCINOMA, LEFT LUNG							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT OLD
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ARTERIOSCLEROTIC HEART DISEASE, OLD. SURGICAL ABSENCE, SPLEEN, RECENT. SURGICAL ABSENCE, COLON AND RECTUM, OLD. BENIGN PROSTATIC HYPERTROPHY, OLD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (he/she) (this hospital) attended the deceased from 9/16/68 , 19 68 , to 9/20/68 , 19 68 , that (he/she) (we) lost saw the deceased alive on 9/20/68 , 19 68 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (he/she) (we) (did/did not) view the body after death.							
22b. SIGNATURE <i>Krishna V. S. Rao</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/20/68	
22d. PHYSICIAN'S NAME (Type) KRISHNA V. S. RAO, M. D.				22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-23-1968		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR GEORGE J. GONCE FUNERAL HOME				25a. REC'D BY REGISTRAR SEP 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12727

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12733

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. 10 P M				
CLAUDE CHARLES TRUAX						09-05-68			Month Day Year				
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.		
MALE		CAU		9-12-96			71 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
New York		USA					BALTIMORE COUNTY Md.						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON, MD.				Greater Baltimore Med. Cent. Plumber				H. A. Warfield Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND				BALTIMORE		Dundalk				8101 COYNE DRIVE			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
POMEROY TRUAX				EDITH DYKMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT Address							
				056-12-3391		PATIENTS CHART							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621													
DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER RESPIRATORY INSUFFICIENCY													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) LUNG CANCER													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
163x													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-31-68, 19, to 9-05, 1968, that (I) (we) last saw the deceased alive on 10:35 PM 9-5-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								22c. DATE SIGNED					
Doct Mhd. MD DEGREE								ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			9 9-06-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
DR. MOHAMMAD						GBMC							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			9/9/68		Moreland Memorial Park			Baltimore, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John J. Duda, 7922 Wise Ave. Dundalk, Md.						DATE SEP 11 1968			J Charles Judge				



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

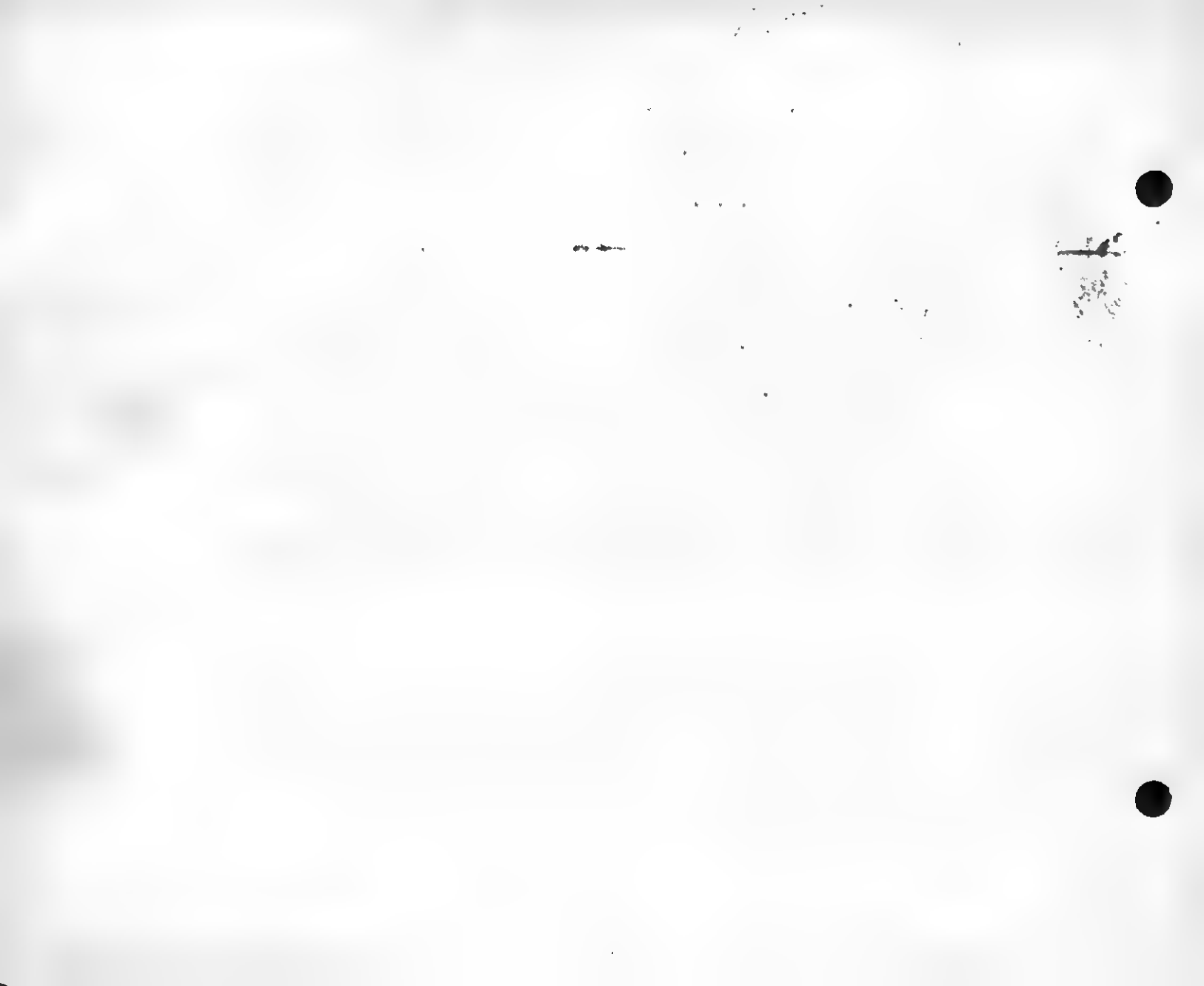
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12722										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12734																																																																					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																																																									
1. DECEASED NAME (Type or Print)										First Middle Last										2a. DATE KNOWN OF DEATH										2b. HOUR																																																											
BILLY FRANCIS TUCKER																				19										M																																																											
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										7. IF UNDER 1 YEAR										8. IF UNDER 24 HRS										2c. DATE PRONOUNCED DEAD										10. HOUR																			
male										white										Oct. 28, 1925										42 YRS										MONTHS DAYS										HOURS MIN										September 2,										1968										a. 10:30									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md																																																	
10. CITY OR TOWN OF DEATH										11. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																																																					
Essex										Sheet Metal Worker										Aircraft																																																																					
13a. USUAL RESIDENCE (Where deceased lived, if an institution, residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY, IN 15'										13e. STREET AND NUMBER																																																	
Maryland										Baltimore										Middle River										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										224 Ballard Avenue																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																															
Will Tucker										Ruth Henry																																																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO										17. INFORMANT										ADDRESS																																																											
Yes										44-46										245 28 9120										Elizabeth Tucker										Same																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART 1. DEATH WAS CAUSED BY:																																																																																									
IMMEDIATE CAUSE (a)										Manual Strangulation																																																																															
963 X																																																																																									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																																																																															
										DUE TO, OR AS A CONSEQUENCE OF																																																																															
										(c)																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																																									
983 X																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																																					
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)																																																																					
CAUSE OF DEATH										HOUR A.M. UNKN UNK 19										subj. beaten about head and strangled																																																																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No										City or Town										County										State																																							
										woods																				Baltimore, Md.																																																											
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspect on <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from										Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																															
ACTUAL SIGNATURE										Werner U. Spitz, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										22b. DATE SIGNED																																																	
EXAMINER'S NAME (Type)																				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																				9/3/68																																																	
ADDRESS (Street, city, town or county)																																																																																									
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town)										(County)										(State)																																							
Removal										9/4/68										Moore Funeral Home										wadesboro, N.C.																																																											
24. FUNERAL DIRECTOR										ADDRESS										25a. RECD BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Brazdzinski Funeral Home										1407 Eastern Ave.										DATE										SEP 5 1968										Charles Judge																																																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-2-68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12725										12735									
1. DECEASED-NAME (Type or print) First Middle Last Fred. J. Van Slyke										2a. DATE OF DEATH Month Day Year 9 22 1968									
3. SEX Male										4. RACE Cau.									
5. DATE OF BIRTH 7-6-1895										6. AGE (In years lost birthday) 73 YRS									
7a. BIRTHPLACE (State or foreign country) Detroit										7b. CITIZEN OF WHAT COUNTRY? U.S.A.									
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore									
10. CITY OR TOWN OF DEATH Towson										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 113 Greenbriar Rd									
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self Employed										12b. KIND OF BUSINESS OR INDUSTRY Lawyer									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Baltimore									
13c. CITY OR TOWN Towson										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e. STREET AND NUMBER 113 Greenbriar Road 4																			
14. FATHER'S NAME First Middle Last John K. Van Slyke										15. MOTHER'S M.A.DEN. NAME First Middle Last Jessie Root									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) Yes W.W. I										16b. SOCIAL SECURITY NO 218-36-5641									
17. INFORMANT Address Antoinette Van Slyke 113 Greenbriar Road 4																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary unknown DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from July , 19 68 , to Sept , 19 68 , that (I) (we) last saw the deceased alive on Sept 21st , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE Francis T. Daly M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED SEP 23 1968									
22d. PHYSICIAN'S NAME (Type) FRANCIS T. DALY										22e. ADDRESS 3201 N. Charles St									
23a. BURIAL, CREMATION REMOVAL (Specify) Burial										23b. DATE 9-25-1968									
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md									
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236										25a. REC'D BY REGISTRAR SEP 25 1968									
25b. REGISTRAR'S SIGNATURE J. Charles Judge																			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12726

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12736

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOLR 3d
JACOB		CARL	VITAK	2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HQJR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	September		19	68	54
male	white	7/21/1891	77 YRS			September		19	68	54
7a BIRTHPLACE (State or foreign country)		7b. CT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Czechoslovakia		U.S.A.		Baltimore						
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if not red.)		12b KIND OF BUSINESS OR INDUSTRY				
Towson		1606 Loch Ness Rd.		Ret-Cabinet Maker		self employ				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13a STREET AND NUMBER		
Md.		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2513 E. Madison St.		
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
unknown					unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		1938 Altavue Rd		21228		
no		212-01-3561A		Mrs. Lloyd L. Klein, Jr.		Dght.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO OR AS A CONSEQUENCE OF <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Ischaemic heart disease</u> DUE TO OR AS A CONSEQUENCE OF <u>4 yrs</u> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Charles F. O'Donnell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED
EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		9/19/68
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		9/21/68		Bohemian National Cem.		Baltimore, Md.				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Schimunek Funeral Home, Inc.		2601 E. Madison St.		DATE SEP 23 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

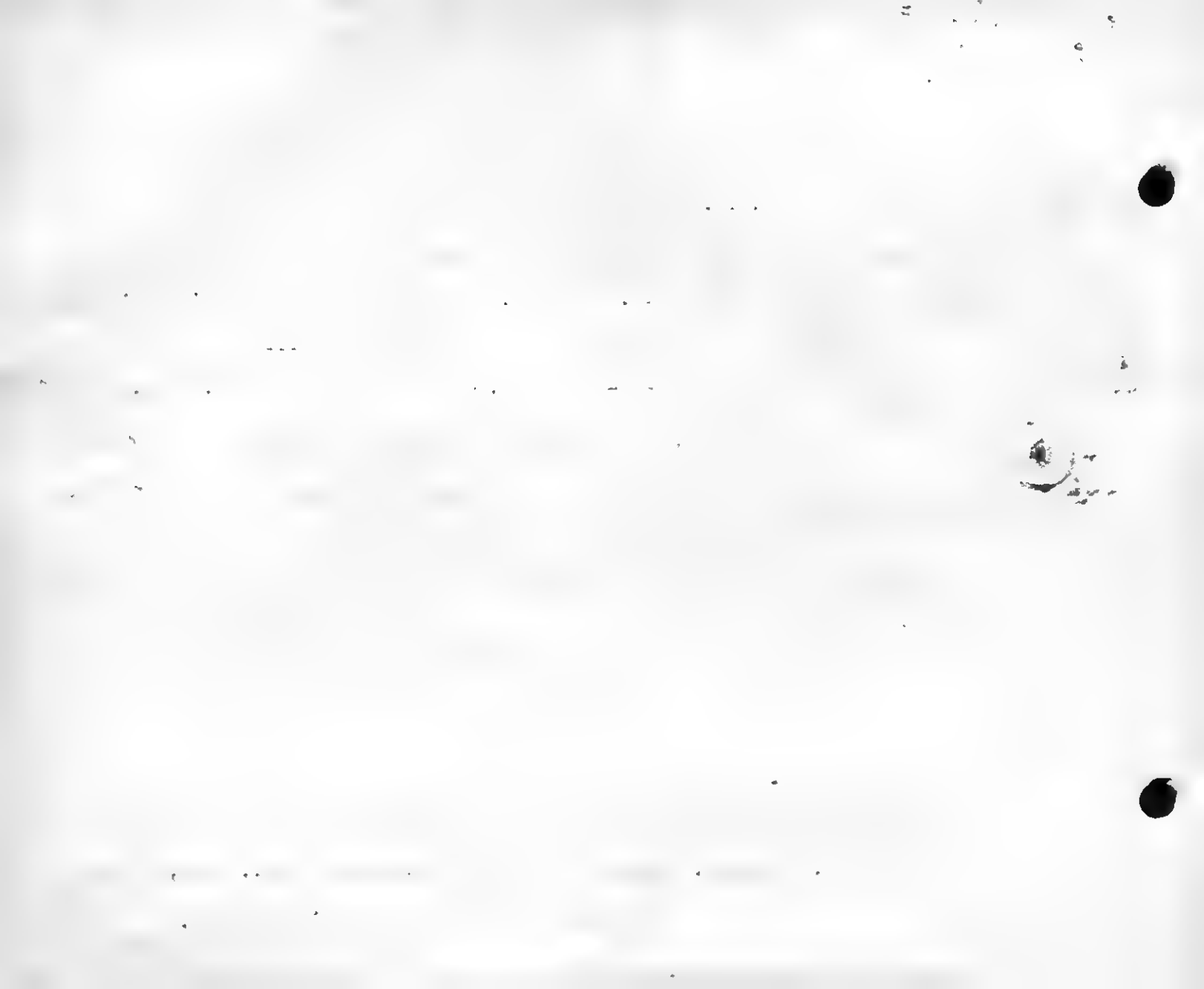
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12727

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 127238
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Michael			First Middle Last Volpe			2a. DATE OF DEATH Month Day Year Sept 18 68			2b. HOUR 9:25 M		
3. SEX male			4. RACE white			5. DATE OF BIRTH April 28 1889			6. AGE (In years lost birthday) 79 YRS		
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Calonsville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE Maryland COUNTY Balto.			13c. CITY OR TOWN Balto.			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b. STREET AND NUMBER 5019 Balto. Natl. Pike		
14. FATHER'S NAME First Middle Last Frank Volpe			15. MOTHER'S MAIDEN NAME First Middle Last Catherine								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 191-03-2067			17. INFORMANT Address Mr. John Volpe, 5019 Balto. Natl. Pike, 21229					
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS 5-10 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC URINARY TRACT INFECTION 6 YEARS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from August 1960 , to September 18, 1968 , that (I) (we) last saw the deceased alive on Sept 18 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Melvin N. Borden						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 9/19/68		
22d. PHYSICIAN'S NAME (Type) Dr. Melvin N. Borden						22e. ADDRESS 5000 Baltimore Natl. Pike, 21229					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/21/68			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229						25a. REC'D BY REGISTRAR DATE SEP 20 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

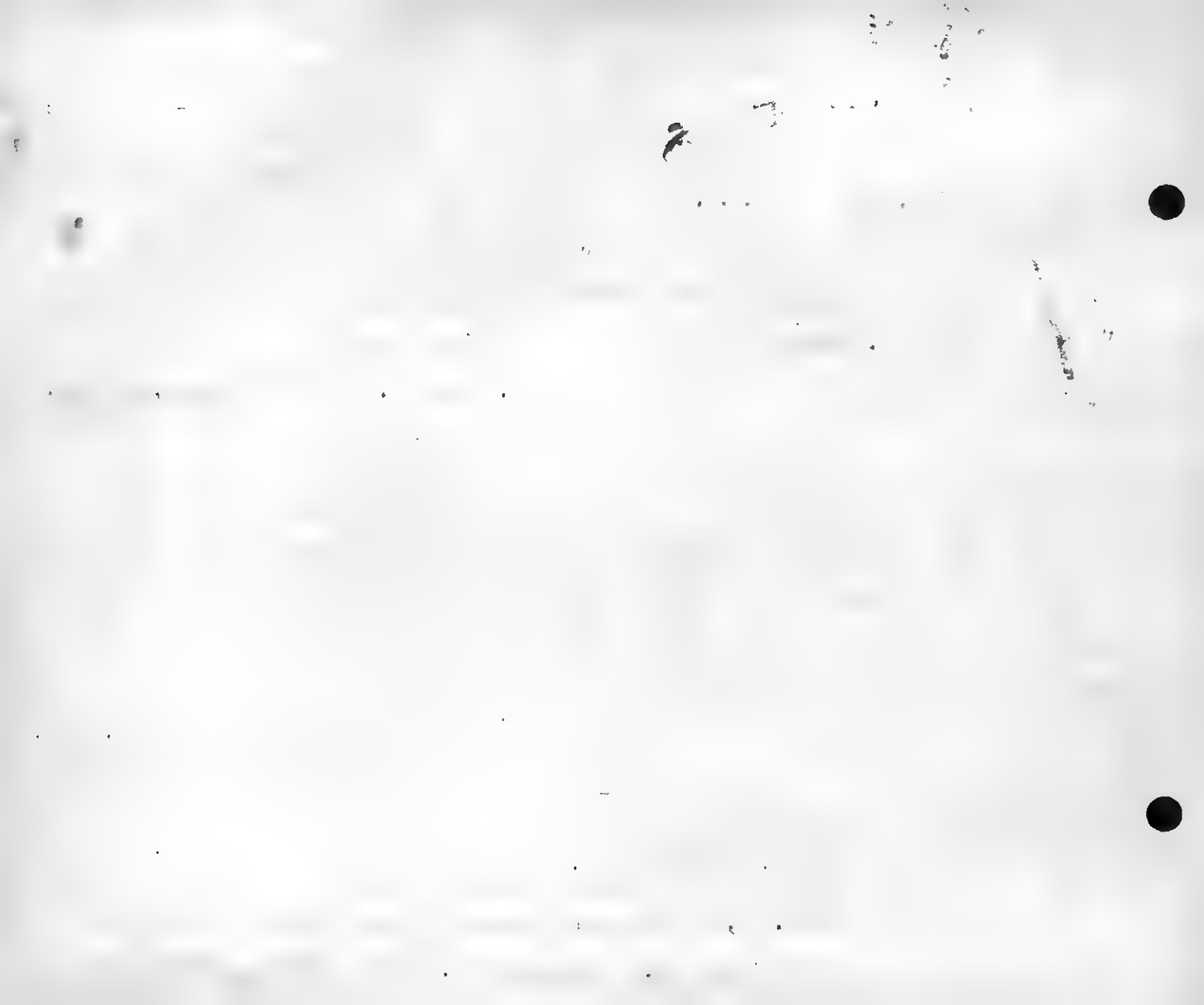


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>12728</div> <div>Item #21b, Film 3</div> <div>12737</div>											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) RONALD Wayne WADDELL						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 9 Day 20 Year 1968			2b. HOUR 5:20 PM		
3 SEX Male		4. RACE White		5 DATE OF BIRTH March 30, 65		6 AGE (In years last birthday) 3 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Balto. City				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Randallstown				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Howard		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Woodstock Rd, Box 98	
14 FATHER'S NAME First Howard C. Middle Waddell						15 MOTHER'S MAIDEN NAME First Diana Middle Palmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Howard C. Waddell				ADDRESS Box 98 St. Paul Ave, Grant Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries of upper cervical spine DUE TO, OR AS A CONSEQUENCE OF (b) 81477 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 6-19 68 6:45 PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pedestrian struck by car					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION (Street or R.F.D. No. City or Town County State) St. Paul Ave. 30 feet East of Hertwood Rd. Balt. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate				M.D. Charles S. Springate, M.D.				22b. DATE SIGNED Sept. 21, 1968			
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 23, 68		23c. NAME OF CEMETERY OR CREMATORY Finksberg Memorial Garden		23d. LOCATION (City or Town) (County) (State) Finksberg Maryland					
24. FUNERAL DIRECTOR Loring Byers				ADDRESS 8728 Liberty Rd. Randallstown Md.				25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

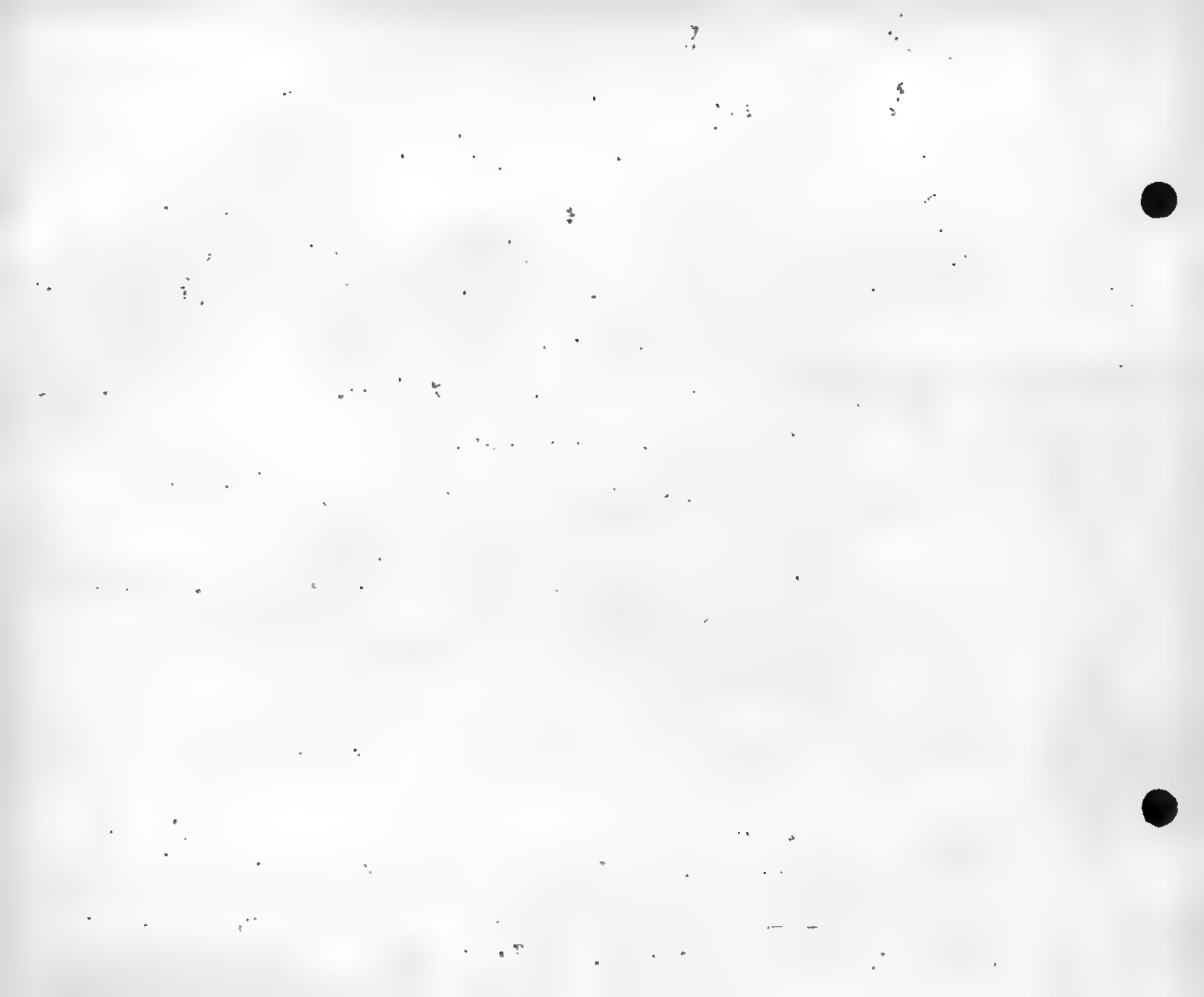
VR 4-14-68
304 REV 4/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

127229

127239

1 DECEASED-NAME (Type or print) <i>Dr. Mary Atala Wagner</i>			2a. DATE OF DEATH 9 Month 14 Day 68		2b. HOUR 4:45 AM
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>11-3-1888</i>		6. AGE (in years last birthday) <i>79</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10 CITY OR TOWN OF DEATH <i>Rural</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Glen Arm Rd.</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>	13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>Glen Arm</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <i>Glen Arm Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Joseph Wagner</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Barbara Schomuck</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>218-54-3339</i>	17 INFORMANT <i>Dr. M. Kathleen</i>		Address <i>Same</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1541 Carcinoma, generalized</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma - 13 years operation colon</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertensive Cardiovascular Disease - 20 years atherosclerosis</i>					
19a. DATE OF OPERATION <i>July 5 1968</i>		19b. OPERATION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 6</i> , 19 <i>66</i> , to <i>Sept 12</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>September 12 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <i>Henry L. McCorkle</i>		DEGREE <i>MD.</i>		22c. DATE SIGNED <i>9-14-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Henry L. McCorkle</i>		22e. ADDRESS <i>Phoenix Md 21131</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>9-16-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sisters Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Glen Arm, Balt. Maryland</i>	
24. FUNERAL DIRECTOR <i>Raymond J. Curran</i>		ADDRESS <i>817 Scarlett Dr. Towson, Md. 21204</i>		25a. REC'D BY REGISTRAR <i>SEP 17 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



12730

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month		Day	Year	12:50 p. M
ODIE		WALKER			SEPTEMBER		7	1968	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER YEAR MONTHS		8 UNDER 24 HRS HOURS
MALE	NEGRO		OCTOBER 26, 1894		73				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMINISTRATION HOSP.		GENERAL LABOR					
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		13b CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		WORTON		YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
RICHARD WALKER					MINNIE TILSON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
YES		WW-1		213 18 5937		CLIN. REC., VAH, FT. HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA AND PULMONARY EDEMA								HOURS	
4129 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								HOURS	
(b) DUE TO, OR AS A CONSEQUENCE OF MASSIVE PULMONARY EMBOLISM								HOURS	
(c) ARTERIOSCLEROTIC HEART DISEASE								YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GRAM NEGATIVE SEPTICEMIA									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION		Street or RFD No		City or Town	County
22a. I certify that (X) (this hospital) attended the deceased from <u>Sept. 3, 1968</u> , to <u>Sept. 7, 1968</u> , that (X) (we) lost saw the deceased alive on <u>Sept. 7, 1968</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYS		MED DIRECTOR		STAFF PHYS	
								22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		MARIO J. QUIROS, M. D.		22e ADDRESS		VET. ADM. HOSP., FT. HOWARD, MARYLAND			
23a BURIAL CREMATON, (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
BURIAL		9/11/1968		MT. OLIVE AME CHURCH CEMETERY		WORTON, KENT		MARYLAND	
24 FUNERAL DIRECTOR		Kenneth Walley Chestertown, Md.		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				DATE SEP 11 1968		f Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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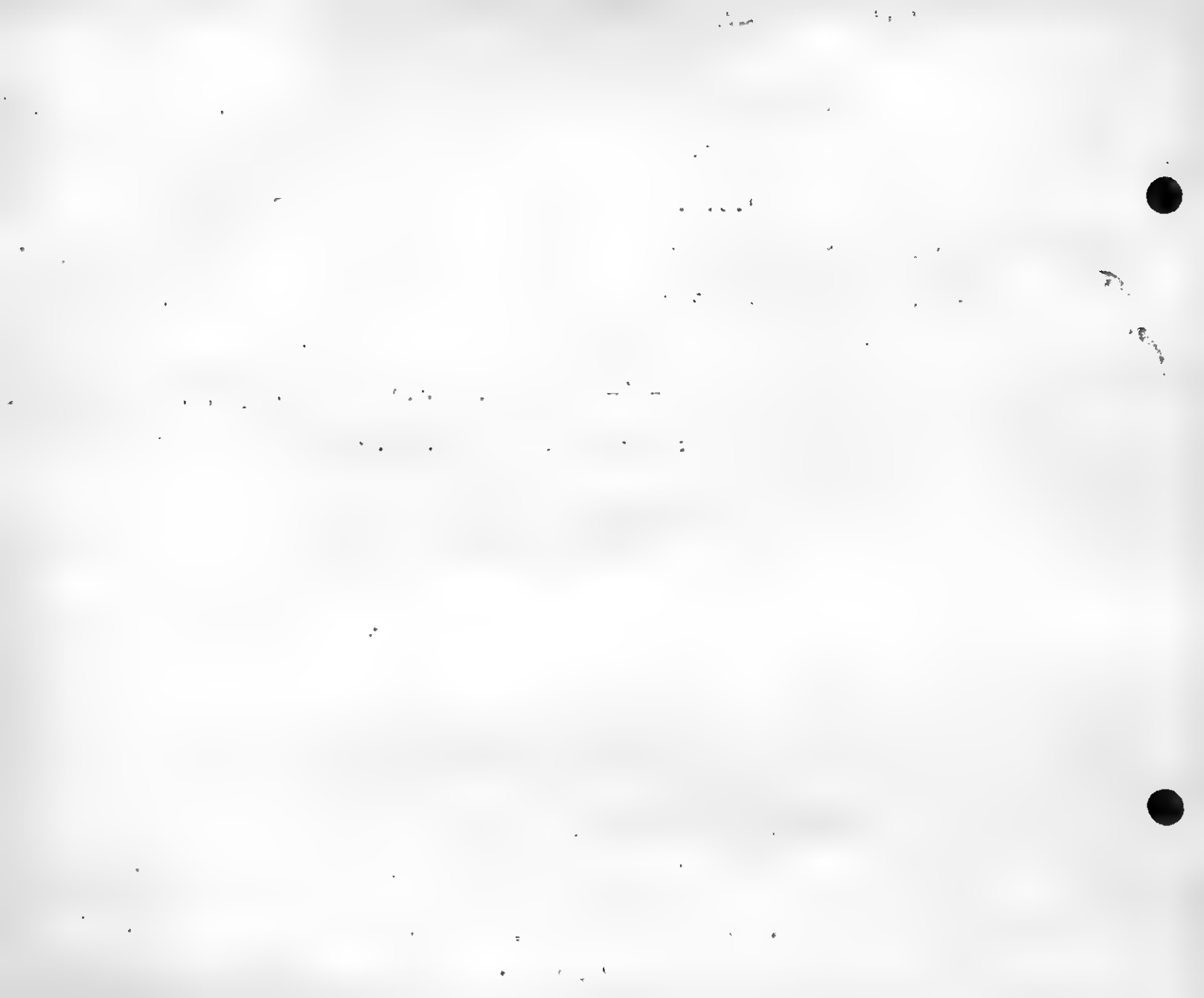
1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15-1
30M RE 1/68

12731										12711														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR am									
Charles Henry Warner										Sept. 15, 1968					11:15									
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		F UNDER 24 HRS		MIN										
Male		White		June 1, 1871		97 YRS		MONTHS		DAYS		HOURS		MIN										
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH															
Maryland			U.S.A.						Baltimore Md.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY															
Reisterstown			Nicodemus Road			Constable			Balto. City.															
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER												
Maryland			Baltimore			Reisterstown						Nicodemus Road												
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
John Warner					Margaret																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No					218-16-1185					Mrs. Louis Eckhart					Rt. #2 Box 371 Reisterstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u>															5 yrs									
4127 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																								
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																								
(c) _____																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
422																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (the hospital) attended the deceased from 2-4-68, 19, to 9-15-68 19, that (I) (we) last saw the deceased alive on 9-14-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																								
22b. SIGNATURE					22c. DATE SIGNED																			
A. D. Caples M. D.					9-17-68																			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																			
D. D. Caples, M. D.					6 Hanover Rd., Reisterstown, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					Sept. 18, 1968					London Park Cemetery					Baltimore, Maryland									
24 FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
H. J. Eckhardt					Owings Mills, Md.					DATE SEP 18 1968					Charles Judge									



12732

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12742

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 5:30 PM		
Arthur		Lipps		Wattenscheidt	September 17, 1968				
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		
male	white		April 28, 1896		72 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Md.	U. S.				Baltimore Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Catonsville		SPRING GROVE STATE HOSP.		salesman					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		B		Balto.				522 St. Paul St.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Rudolph		Louisa							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address					
(If yes give war or dates of service)		219-07-0734		Records: SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute pneumonia, necrotic</i>									
DUE TO, OR AS A CONSEQUENCE OF <i>Cardiovascular shock due to</i>									
(b) <i>Myocardial infarction or</i>									
DUE TO, OR AS A CONSEQUENCE OF <i>myocardial infarction.</i>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical exam ner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f LOCATION Street or RFD No City or Town County State					
22a I certify that (X) (this hospital) attended the deceased from June 1, 19 56 to Sept. 17 19 68, that (X) (we) last saw the deceased alive on Sept. 17 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
<i>Rafael H. Marin</i>		9/15/68							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
Rafael H. Marin, M.D.		SPRING GROVE STATE HOSPITAL Baltimore, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Oct. 1, 1968		Landon Park Cemetery		Baltimore Md.			
24 FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<i>Frank D. Senell</i>		<i>Frank D. Senell</i>		DATE OCT 2 1968		<i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Kurt			Middle Weikers			Last Weikers			2a. DATE OF DEATH Month 9 Day 5 Year 68		2b. HOUR 7A M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH Jan. 16th. 1904			6. AGE (In years last birthday) 64 YRS.			IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) Germany			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6611 Amleigh, Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Representative Furniture			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 6611 Amleigh, Rd.			
14. FATHER'S NAME Ignaz			First Ignaz			Middle Weikers			Last Weikers			15. MOTHER'S MAIDEN NAME Mina			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-16-8234			17. INFORMANT Susan Weikers			Address 2706 Smith, Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cause of Bone (Spond)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 month			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 31</u> to <u>Sept 5</u> 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>Sept 5</u> 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Dr. Joseph Gross</u>						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-5-68					
22d. PHYSICIAN'S NAME (Type) Dr. Joseph Gross						22e. ADDRESS 6911 Paul Street									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-6-68		23c. NAME OF CEMETERY OR CREMATORY Chevera Ahavas Chesed Inc.				23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)			
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son						ADDRESS P.O. Box 65 Garrison, Md.		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>					

MARYLAND STATE D

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12734										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12744									
1 DECEASED-NAME (Type or Print) <u>Rouse</u> First <u>NMI</u> Middle <u>W.E.</u> Last <u>W.E.</u>										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>9</u> Day <u>14</u> Year <u>1968</u> 2b HOUR <u>10:30</u> EST. <u>P.M.</u>																			
3 SEX <u>M</u>		4 RACE <u>W</u>		5 DATE OF BIRTH <u>May 10 1910</u>		6 AGE (In years last birthday) <u>58</u> YRS		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>		2c DATE PRONOUNCED DEAD Month <u>9</u> Day <u>14</u> Year <u>1968</u>				2d HOUR <u>11:30</u> P.M.													
7a BIRTHPLACE (State or foreign country) <u>England</u>				7b CITIZEN OF WHAT COUNTRY? <u>USA.</u>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <u>Baltimore</u>				Md													
10 CITY OR TOWN OF DEATH <u>Baltimore</u>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>3232 Joppa Rd.</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Asst. Mgr.</u>				12b KIND OF BUSINESS OR INDUSTRY <u>---</u>																	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md</u>				13b COUNTY <u>Baltimore</u>				13c CITY OR TOWN <u>Baltimore</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>3232 E Joppa Rd.</u>																	
14 FATHER'S NAME First <u>Frederick A</u> Middle <u>Holland</u> Last <u>Louisa</u>				15 MOTHER'S MAIDEN NAME First <u>Louisa</u> Middle <u>Phillips</u> Last <u>Phillips</u>																									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16b SOCIAL SECURITY NO. <u>Unk.</u>				17 INFORMANT <u>Kathleen Triffinger</u>				ADDRESS <u>8420 Loch Raven B</u>																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Previous Myocardial Infarct & Congestive Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>---</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10-15 min</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (p) <u>Convalescing from Aphasia, Hemiplegia, Cerebrovasc. Disease Apr 68</u>																													
19a DATE OF OPERATION <u>---</u>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>---</u>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>---</u>				21b TIME OF INJURY Month, Day, Year <u>---</u> HOUR A.M. <u>---</u> P.M. <u>19</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>---</u>																					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>---</u>				21f LOCATION Street or R.F.D. No <u>---</u> City or Town <u>---</u> County <u>---</u> State <u>---</u>																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <u>Franky. Kask</u>				EXAMINER'S NAME (Type) <u>F.T. KASK</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED <u>9/14/68</u>																	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE <u>9/17/68.</u>				23c NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cemetery</u>				23d LOCATION (City or Town) <u>Baltimore</u> (County) <u>---</u> (State) <u>---</u>																	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>										25a REC'D BY REGISTRAR <u>SEP 16 1968</u>				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12735

• DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12715

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Sol		First S. Middle W. Last WEISSBERG		DATE OF DEATH Sept Month 21 Day Year 1968		2b. HOUR 7:40	
3 SEX MALE		4. RACE Caucasian		5 DATE OF BIRTH 2-14-1901		6 AGE (In years lost birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County	
10 CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Manor Nurs Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) DRAFTSMAN		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e. STREET AND NUMBER 5808 Ethelbert Ave.		14 FATHER'S NAME First SAMUEL Middle WEISSBERG Last RIFKA		15 MOTHER'S MAIDEN NAME First RIFKA Middle ? Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 272-10-7855		17 INFORMANT MRS. SYLVIA WEISSBERG, 5808 ETHELBERT AVE.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Carcinoma to liver DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Pancreas DUE TO, OR AS A CONSEQUENCE OF (c) 						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos 5 mos	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none							
19a. DATE OF OPERATION July 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 5 , 19 68 , to Sept 21 , 19 68 , that (I) (we) last saw the deceased alive on Sept 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (d) did not view the body after death.							
22b. SIGNATURE H. Gerald Oster MD				DEGREE MD		22c. DATE SIGNED 9-21-68	
22d. PHYSICIAN'S NAME (Type) H. GERALD OSTER				22e. ADDRESS 6821 Reisterstown Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-22-68		23c. NAME OF CEMETERY OR CREMATORY ABRAHAM SHALOM		23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR SEP 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12736

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12746

1. DECEASED-NAME (Type or print) First Middle Last MARY WILES			2a. DATE OF DEATH Month Day Year 9 2 68		2b. HOUR 44 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 3/21/13		6. AGE (In years lost birthday) 55 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.	
10. CITY OR TOWN OF DEATH Mount Wilson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY BALTI	13c. CITY OR TOWN PIKESVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 106 CLARK AND AVE.	
14. FATHER'S NAME First Middle Last CHARLES SUMMERFIELD BUCKINGHAM			15. MOTHER'S MAIDEN NAME First Middle Last ANNA MYERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO 220-46-3541		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema & Congestive Heart Failure 472x DUE TO, OR AS A CONSEQUENCE OF (b) Obstruction of the airway by mucopurulent secretions DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema chronic, hypertrophic obstructive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 10st PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5271					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/24, 1968, to 9/2, 1968, that (I) (we) last saw the deceased alive on 9/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Newcomer				22c. DATE SIGNED 9/3/68	
22d. PHYSICIAN'S NAME (Type or print) William Newcomer, M.D.				22e. ADDRESS Mount Wilson State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Sept. 5, 68	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR J. F. Elme & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR DATE SEP 4 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

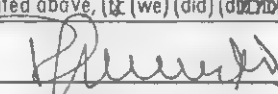


VR 15
30M REV 1/68

12737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12717

1. DECEASED-NAME (Type or print) ROBERT			First LEE			Middle WILEY			Last			2a. DATE OF DEATH Month 9 Day 3 Year 68			2b. HOUR 10:30 PM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7/18/97			6. AGE (In years last birthday) 71 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign) BALTIMORE, MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md.								
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) FT. ADM. HOSPITAL			12a. USUA. OCCUPAT. ON (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY COTTON MILLS								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY W			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1417 W. 36th Street					
14. FATHER'S NAME ROBERT			First WILEY			Last			15. MOTHER'S MAIDEN NAME CARRIE			First KENNEDY			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO. WW 1			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4344 (b) HYPERTENSION OF LESSER CIRCULATORY (COR PULMONALE) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BASAL CELL CARCINOMA SKIN OF NOSE																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month 9 Day 3 Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 8/28/68 , 19____, to 9/3/68 , 19____, that (I) (we) last saw the deceased alive on 9/3/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/4/68								
22d. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M. D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE SEP. 6, 1968			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND								
24. FUNERAL DIRECTOR 			ADDRESS NEWELL FUNERAL HOME			25a. REC'D BY REGISTRAR SEP 13 1968			25b. REGISTRAR'S SIGNATURE 								
REISTERSON RD. & WATSON AVE. BALTIMORE, MD																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12738
CERTIFICATE OF DEATH
12748

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>3 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1206 Longford Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura Gainer Wilfong</u>		4. DATE OF DEATH Month Day Year <u>September 17 1968</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1964</u>
9. AGE (In years last birthday) <u>3 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James William Wilfong</u>		14. MOTHER'S MAIDEN NAME <u>Dorothea W. Wilfong KOLDYS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma with widespread metastases</u> DUE TO (b) <u>1929</u> DUE TO (c) <u>15 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <u>this hospital</u> attended the deceased from <u>September 14, 1968</u> to <u>Sept 17, 1968</u> , that (1) <u>last</u> saw the deceased alive on <u>Sept 17, 1968</u> , and that death occurred at <u>8:00 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry S. Crist</u>		22b. DATE SIGNED <u>Sept 17, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry S. Crist M.D.</u>		22d. ADDRESS <u>1216 Longford Rd, Lutherville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 19, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY MEM.</u>		23d. LOCATION (City, town or county) (State) <u>COCKEYSVILLE, MD.</u>	
24. FUNERAL DIRECTOR <u>John Burris' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 23 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>gcharles judge</u>	

12739

CERTIFICATE OF DEATH

12719

1. DECEASED NAME (Type or print) TINA			First Middle Last M. WILHITE			2a. DATE OF DEATH Month Day Year Sept. 22, 1968			2b. HOUR M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH August 21, 1916			6. AGE (in years lost birthday) 52 YRS.		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Dundalk			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3462 Mc Shane Way			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Steel		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Dundalk			13d. INSIDE CITY L. #157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 3462 Mc Shane Way			14. FATHER'S NAME First Middle Last Ernest Nicholson			15. MOTHER'S MAIDEN NAME First Middle Last Mary C. Skidmore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (if yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Robert Nicholson, 3484 Dunhaven Road			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 1522 DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of sigmoid & liver metastasis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 8, 1968 , to Sept 15, 1968 , that (I) (we) last saw the deceased alive on Sept 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (did not) view the body after death.											
22b. SIGNATURE Samuel D. Gaby, M.D.						DEGREE M.D.			22c. DATE SIGNED 9/23/68		
22d. PHYSICIAN'S NAME (Type) Samuel D. Gaby, M.D.						22e. ADDRESS 3502 W. Rogers Ave.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/25/68			23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			23d. LOCATION (City or Town) (County) (State) Parkville, Md.		
24. FUNERAL DIRECTOR Ulrich Funeral Home, Dundalk, Md.						25a. REC'D BY REGISTRAR SEP 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

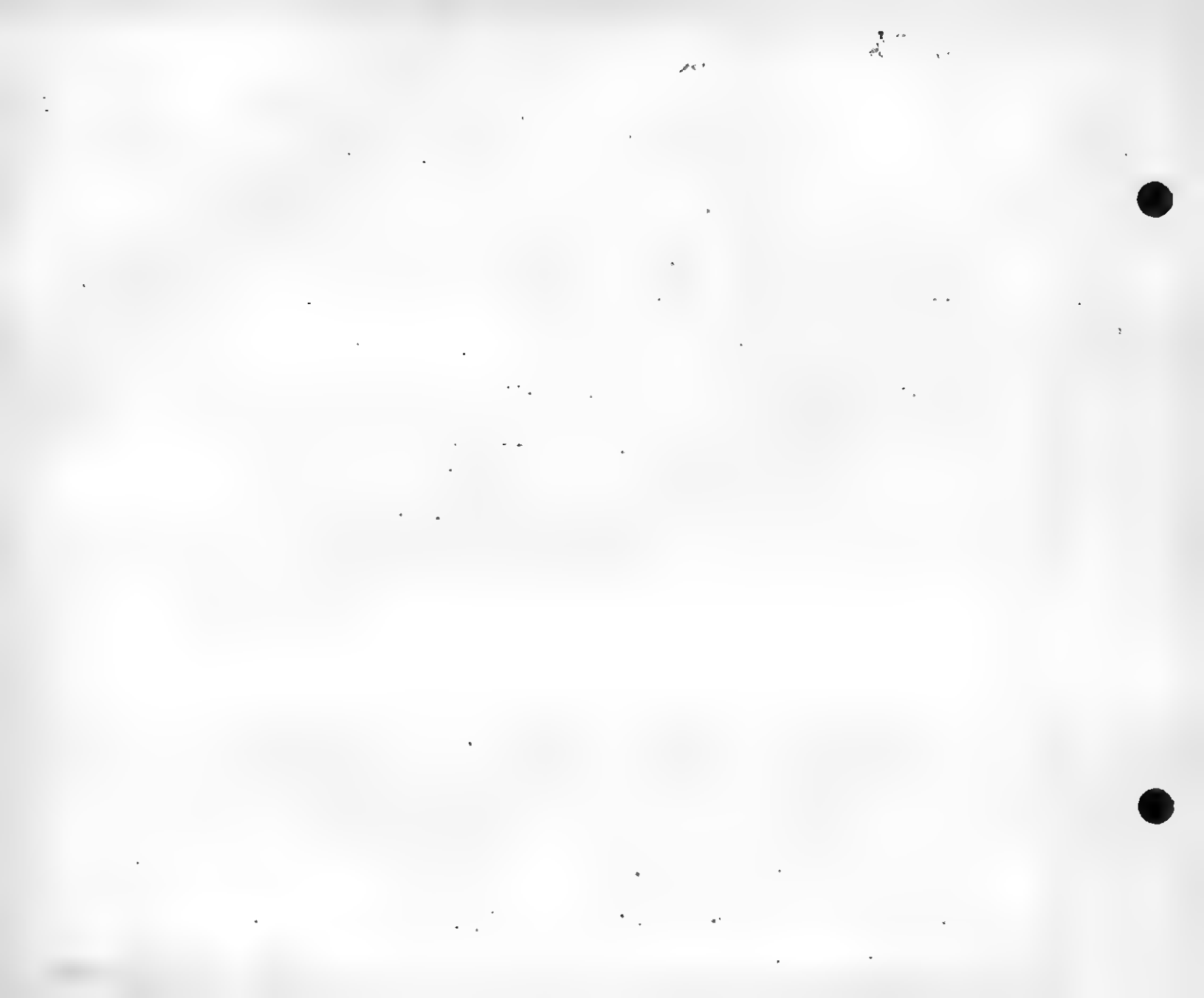


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VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
James E WILLS						September 13, 1968		3:25 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS			
Male		White		July 23, 1896		72 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
D.C.		U.S.A.				Baltimore, Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson			St. Joseph Hospital			PURCHASING AGENT - RET. CAMPBELL					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		238 Linden Ave.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
RICHARD			WILLS			HARRIETT WILLS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown			16b. SOCIAL SECURITY NO		17. INFORMANT			Address			
YES			216-07-3681		FAMILY RECORDS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Encephalomalacia involving the left cerebellar hemisphere											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF severe cerebral arteriosclerosis											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
332X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (X) (this hospital) attended the deceased from 9/6/1968, to 9/13/1968, that (X) (we) last saw the deceased alive on 9/13/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
L. F. Misanik, M. D.								9/13/68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
L. F. Misanik, M. D.			7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		SEPT. 18, 1968		BALTIMORE NATIONAL		BALTIMORE, MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John Burns Sons, Towson Md.				DATE SEP 18 1968		John Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) Artie May Wilmer						2a. DATE OF DEATH Sept Month 9 Day 1968			2b. HOUR M		
3 SEX Female		4 RACE white		5 DATE OF BIRTH June 5, 1886		6 AGE (In year lost birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTH PLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sweet Air Rd				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md				13b. COUNTY —		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1311 W 41st St	
14 FATHER'S NAME First Middle Last William Edward Hunt						15 MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Hare					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO 218505529		17 INFORMANT Address W. Earl Wilmer 1311 W 41st St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency H129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4. Arthritis severe											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 68 to Sept , 19 68 , that (I) (we) lost the deceased alive on Sept 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William A. Tyson						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-9-68			
22d. PHYSICIAN'S NAME (Type) William A. Tyson						22e. ADDRESS Kingsville, Md.					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial		23b. DATE 9-11-68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge				23d. LOCATION (City or Town) (County) (State) Pikesville Balto Md			
24. FUNERAL DIRECTOR Burgee Funeral Home Balto Md						25a. REC'D BY REGISTRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

12742

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13c,e, Film 340L 9/11/68 km

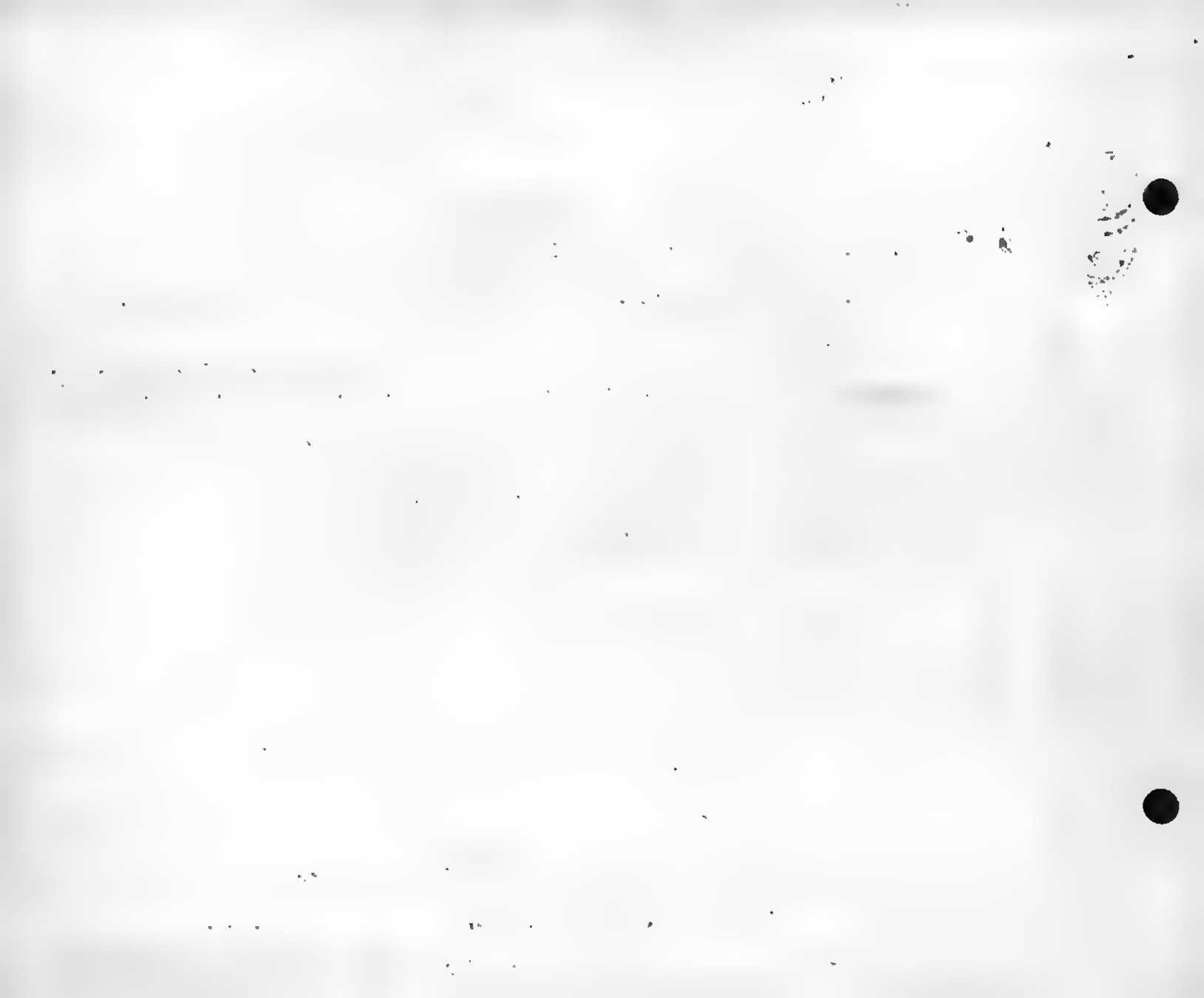
CERTIFICATE OF DEATH

12752

1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Alice					Wilson	9-5-68			3 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
Female		White		7-4-88		86 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Unknown		Unknown				Balto		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Balto. Co.		Forest Haven Nursing Home		Housewife		Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		200 Roland Ave. 315 Ingleside Ave.			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Levy					Burton	Nancy					Tag
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Ave. Catonsville, Md.		
Unknown			212 54 9997			Forest Haven Nursing Home.			315 Ingleside		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - HYPERTENSIVE ORIGIN</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>DISEASE - HYPERTENSIVE ORIGIN</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from <u>11/19, 1967</u> to <u>9/5, 1968</u> , that (I) (we) last saw the deceased alive on <u>9/5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED			
<u>John H. Shaw</u>								<u>9/5/68</u>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<u>John H. Shaw MD</u>		<u>5801 EVERGREEN AVE. BALTO. MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<u>BURIED</u>		<u>9-9-68</u>		<u>N. Cathedral Cem.</u>		<u>Balto. Md.</u>					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Johnson Funeral Home, 8521 Loch Raven Blvd.</u>		<u>21204</u>		<u>SEP 9 1968</u>		<u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

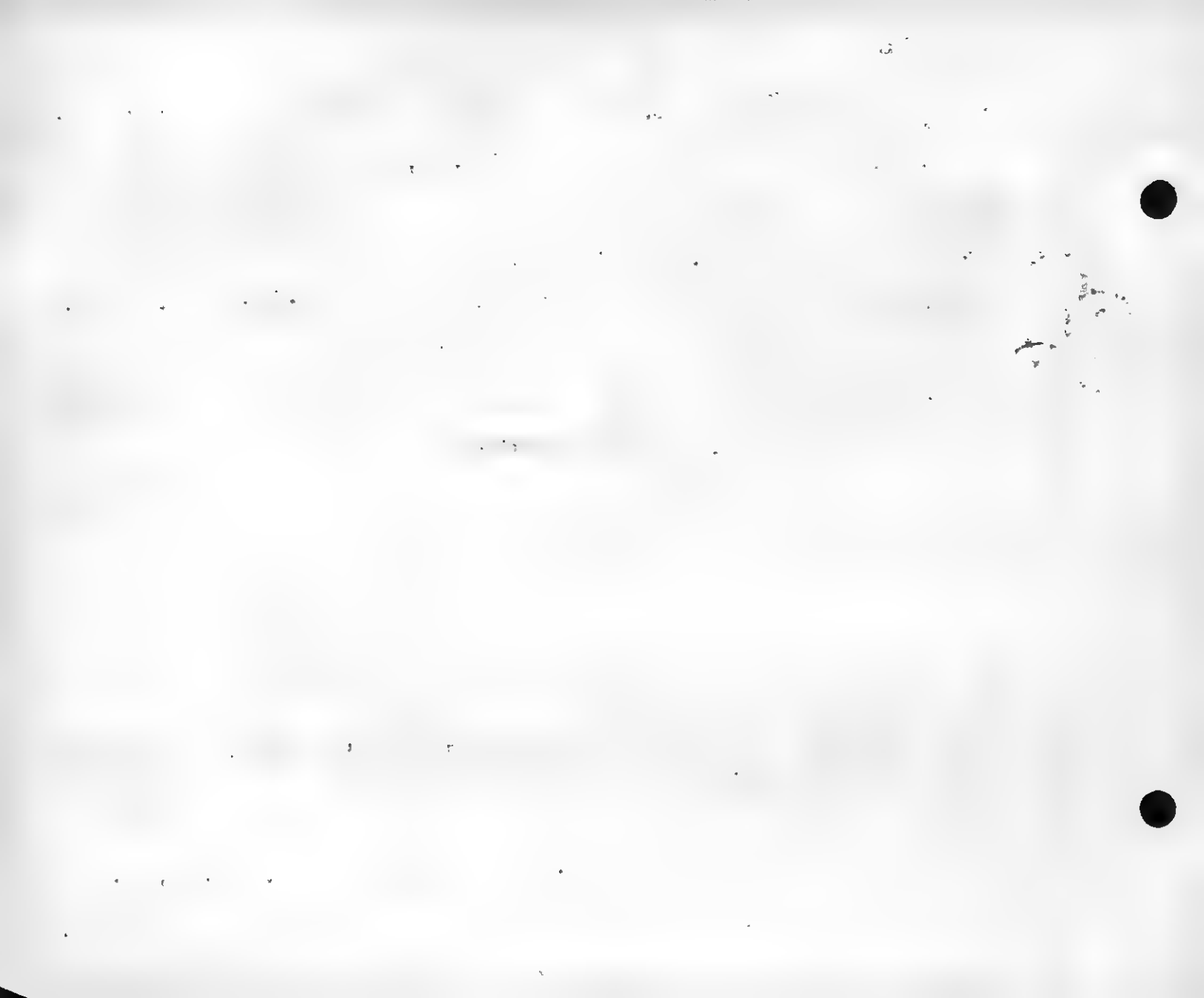
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12743 CERTIFICATE OF DEATH 12753									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>409 York Road</u>					d. STREET ADDRESS <u>409 York Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Charlotte</u> Middle <u>Wilhelmina</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1968</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1880</u>		9. AGE (in years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Herman Moog</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Zimmerman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>None</u>		17. INFORMANT <u>Family Records</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4121</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>58</u> to <u>SEP 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>68</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>T. C. Siwinski</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/22/68</u>			
22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>				22d. ADDRESS <u>206 W. Penna. Ave., Towson, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 23, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR <u>SEP 24 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (carefully) filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12744		12751										
1 DECEASED NAME (Type or print) First Middle Last FLORENCE E. WILSON						2a DATE OF DEATH Month Day Year SEPT 4 1968			2b HOUR 7:44PM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH OCT. 24, 1890			6 AGE (In years lost birthday) 77 YRS.		IF UNDER YEAR MONTHS DAYS 77		IF UNDER 24 HRS HOURS MIN 77	
7a BIRTHPLACE (State or foreign country) BALTIMORE		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Balto			Md			
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) ST. JOSEPH'S HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3035 ELM AVE. 21211		
4 FATHER'S NAME First Middle Last George Weichert			15 MOTHER'S MAIDEN NAME First Middle Last Ida Mummert			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) No			16b SOCIAL SECURITY NO. -			
17 INFORMANT L. Eileen Wilson			Address 3035 Elm Ave									
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal infarction												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5702												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from SEPT 1 , 19 68 , to SEPT 4 , 19 68 , that (I) (we) last saw the deceased alive on SEPT 4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE Christina Feliciano, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 9/5/68						
22d PHYSICIAN'S NAME (Type)		22e ADDRESS 7620 YORK RD. TOWSON, MD.										
23a. BURIAL-CREATION, REMOVAL (Specify)		23b DATE 9-9-68		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCAT ON (City or Town) (County) (State) Taylor Ave Balto Md						
24. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS Balto Md		25a REC'D BY REGISTRAR SEP 10 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge						

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12745

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12755

1. DECEASED-NAME (Type or Print) First Charles Martin Winterling Charles Martin Winterling				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 9 11 1968				2b. HOUR 4:15 PM	
3 SEX M		4 RACE W		5 DATE OF BIRTH 7/27/38		6 AGE (In years last birthday) 30 YRS		7 MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) Baltimore				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Balto. Md.				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Arrived D.O.H. 2 Balto. Co Hosp-415 Am. Social Sec. Bldg.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sec. Adm.	
13a. USUAL RESIDENCE (Where deceased lived, if not in institution or residence before admission) STATE Md.				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore	
14 FATHER'S NAME First Albert Middle Winterling Last Stock				15 MOTHER'S MAIDEN NAME First Marie Middle Stock Last Stock				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO 212-36-4009				17 INFORMANT Albert Winterling Sr.				ADDRESS 6415 Ridgeview Ave.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death Coronary occlusion 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE J. Nelson McKay				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 9/12/68	
EXAMINER'S NAME (Type) J. Nelson McKay M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9-14-1968				23c. NAME OF CEMETERY OR CREMATORY Sacred Heart	
24. FUNERAL DIRECTOR Lilly & Zeiler Inc.				ADDRESS 1901-07 Eastern Ave.				25a. REC'D BY REGISTRAR SEP 16 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge				25c. ADDRESS (Street, city, town, or county)				25d. DATE	

6719 Harford Rd.
Hersheyfield

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12746		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12756	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) CLARENCE E. WOODEN			2a. DATE OF DEATH Month SEPT Day 19 Year 1968		2b. HOUR 9:15 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MAY 21 1906		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4730 GATEWAY TERRACE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY DOOR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY BALTO.	13c. CITY OR TOWN ARBUS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4730 GATEWAY TERRACE	
14. FATHER'S NAME First GEORGE Middle E Last WOODEN		15. MOTHER'S MAIDEN NAME First MELLIE Middle ROBERTS Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 210-106790		17. INFORMANT Name Clarence E. Wooden Jr. Address 4730 Gateway Terrace, Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 241X (b) SEVERE PROGRESSIVE OBSTRUCTIVE EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE ALLERGIC (ASTHMATIC) BRONCHITIS 12 YEARS 15 YEARS.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RECENT PNEUMOCOCCAL PNEUMONIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/19 , 19 56 , to 9/19 , 19 68 , that (I) (we) last saw the deceased alive on 9/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John H. Hirschfeld M.D.		22c. DATE SIGNED 9/20/68		22d. PHYSICIAN'S NAME (Type) JOHN H. HIRSCHFELD M.D.	
22e. ADDRESS 6919 HARFORD ROAD BALTO 21234					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-21-68		23c. NAME OF CEMETERY OR CREMATORY Linden Park Cem.	
23d. LOCATION (City or Town) (County) (State) Balto. Md.					
24. FUNERAL DIRECTOR Foley, Conway & Co.		24a. REC'D BY REGISTRAR DATE SEP 23 1968		24b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

12747

127517

1. DECEASED-NAME (Type or print)		First Daisy	Middle I.	Last Ziegler	2a. DATE OF DEATH Month Day Year September 25, 1968		2b. HOUR M
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 30, 1875		6. AGE (In years last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Lawford & McKim	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER 2916 Dummurphy Road	
14. FATHER'S NAME First Middle Last William H. Ziegler		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ellen ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) 16b. SOCIAL SECURITY NO. 212-03-3468			
17. INFORMANT (Nephew) Address Dundalk, Md. Mr. William A. Ziegler, 2916 Dummurphy Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4319 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 ch
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>67</u> , to <u>25 Sept</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William Goodman</u>		DEGREE M.D.		22c. DATE SIGNED Sept. 26, 1968		22d. PHYSICIAN'S NAME (Type) William Goodman	
22e. ADDRESS 1334 Sulphur Spring Rd. Balto. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/28/68		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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